

CERTIFICATE OF DEATH

13380

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards		c. LENGTH OF STAY IN 1b 52 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Main St.		d. STREET ADDRESS Main St.	
3. NAME OF DECEASED (Type or print) HANDY CARLTON ADKINS		4. DATE OF DEATH Month September Day 24 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1 1891
9. AGE (In years lost birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min. 75	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agent		10b. KIND OF BUSINESS OR INDUSTRY Fire Insurance	
11. BIRTHPLACE (County & State, or foreign country) Wicomico, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Handy A. Adkins		14. MOTHER'S MAIDEN NAME Minnie Wilkins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-30-9717	
17. INFORMANT C. M. "Tommy" Adkins, Salisbury, Md.		18. ADDRESS Pinehurst Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO (c) hypertension		INTERVAL BETWEEN ONSET AND DEATH 5 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1957 , 19 9-24 , 1966, that (I) (we) lost saw the deceased alive on 9-24 1966, and that death occurred at 3:47 M, from causes on and the date stated above.			
22a. SIGNATURE Frank R. Lewis		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Frank R. Lewis MD		22d. ADDRESS Willards, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/27/1966	
23c. NAME OF CEMETERY OR CREMATORY Parsons		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR Gerald C. Brown		25a. REC'D BY REGISTRAR SEP 28 1966	
ADDRESS Snow Hill, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13350

UNITED STATES OF AMERICA

13350

Location: [illegible]
Date: [illegible]
Time: [illegible]
By: [illegible]

U. S. DEPARTMENT OF AGRICULTURE

Field No. [illegible]
Date of Collection [illegible]
Locality [illegible]
Collector [illegible]
Plant Name [illegible]
Plant Part [illegible]
Plant Use [illegible]
Plant Description [illegible]

Plant Description [illegible]
Plant Use [illegible]
Plant Description [illegible]
Plant Use [illegible]

Plant Description [illegible]
Plant Use [illegible]
Plant Description [illegible]
Plant Use [illegible]

Plant Description [illegible]
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Plant Description [illegible]
Plant Use [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
13387										
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 22-1 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 107 Glenwood Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Dorothea Elizabeth Albert					4. DATE OF DEATH Month Day Year September 10 1966					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 27, 1925		9. AGE (In years last birthday) 41 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME James S. Williams, Sr.					14. MOTHER'S MAIDEN NAME Estelle Williams					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 227-20-3646		17. INFORMANT Address Lawrence Albert Salisbury, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of Liver 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH 2 mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 9/4 , 19 66 , to 9/10 , 19 66 that (I) (we) last saw the deceased alive on 9/10 19 66 , and that death occurred at 2:14 AM, from the causes and on the date stated above.										
22a. SIGNATURE W B Smith						22b. DATE SIGNED 9/10/66		22c. PHYSICIAN'S NAME (Type) William B. Smith		
22d. ADDRESS						22e. MED. DIRECTOR <input checked="" type="checkbox"/> MED. STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Sept. 13, 1966		23c. NAME OF CEMETERY OR CREMATORY Daisey Cemetery			23d. LOCATION (City, town or county) (State) Chincoteague, Virginia		
24. FUNERAL DIRECTOR ADDRESS Salyer Funeral Home Chincoteague, Virginia						25a. REC'D BY REGISTRAR DATE SEP 13 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

12341

STATE DEPARTMENT OF HEALTH

Division of

Sanitation

Department of Health

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md. b. COUNTY Worcester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Stockton d. STREET ADDRESS Box 152 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) WILLIAM First RICE Middle ALLEN Last			4. DATE OF DEATH September 8 1966 Month 8 Year 1966						
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 18, 1892 yrs. 73		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Waterman			11. BIRTH PLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Amos Allen					14. MOTHER'S MAIDEN NAME Sarah Stevenson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 21907-3795		17. INFORMANT Flossie Allen Address Stockton, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO Respiratory Failure (b) 2. Carcinoma of DUE TO lung (c) INTERVAL BETWEEN ONSET AND DEATH 12 hrs years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
MEDICAL CERTIFICATION									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Feb 1965 to Sept 1966 that (I) (we) last saw the deceased alive on Sept 8 1966, and that death occurred at 9:50 AM, from the causes and on the date stated above.									
22a. SIGNATURE David Lapham M.D.					22b. DATE SIGNED 9-11-66				
22c. PHYSICIAN'S NAME (Type) DAVID LAPHAM					22d. ADDRESS New Church, Va.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 9-13-66		23c. NAME OF CEMETERY OR CREMATORY Home Beneficial Cem.		23d. LOCATION (City, town or county) (State) Stockton, Md.		
24. FUNERAL DIRECTOR Charles Judge					25a. REC'D BY REGISTRAR DATE SEP 15 1966				
					25b. REGISTRAR'S SIGNATURE Charles Judge				

1988

Box 122
Stockton
CA

Perinatal General Hospital

Bellevue
Hospital

Labores
Allen

USA

MA

Sarah Stevenson

Stockton, CA

No

Birth record of
Sarah Stevenson
born 11-1-1988

11-1-88

David Allen

Burial 9-13-88 Hope Funeral Home
Stockton, CA

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
13389					CERTIFICATE OF DEATH			13383	
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Wicomico				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN lb 102y		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TYASKIN 22-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital					d. STREET ADDRESS Rte #1 - Box 102			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) OLLIE GEORGE ARMSTRONG First Middle Last					4. DATE OF DEATH September 25, 1966 Month Day Year				
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-14-1915		9. AGE (In years last birthday) 51 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic			10b. KIND OF BUSINESS OR INDUSTRY Auto Mechanic			11. BIRTHPLACE (County & State, or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Eddie Armstrong					14. MOTHER'S MAIDEN NAME Novel Conway				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No			16. SOCIAL SECURITY NO. 21205-3990		17. INFORMANT Luzet Mae Armstrong Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Congestive Heart Failure DUE TO (b) Hypertensive Heart Disease. DUE TO (c) Years								INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypochloremia. Anemia.								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/24/66 , 19 66 , to 9/25/66 , that (I) (we) last saw the deceased alive on 9/24/66 , and that death occurred at 6:30am , from causes and on the date stated above.									
22a. SIGNATURE [Signature]					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-25-66		
22c. PHYSICIAN'S NAME (Type) Osbourne Bueton					22d. ADDRESS Medical Center, Salisbury, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/2/66		23c. NAME OF CEMETERY OR CREMATORY White Haven Cem.		23d. LOCATION (City or Town) (County) (State) White Haven, Md.			
24. FUNERAL DIRECTOR C. Massie, Biv 3/6, MD					25a. REC'D BY REGISTRAR SEP 28 1966		25b. REGISTRAR'S SIGNATURE [Signature]		

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ESTABLISHED IN 1918

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and to any event within 72 hours after death.

13390

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13384

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury 202-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Peninsula General Hospital		d. STREET ADDRESS 141 Second St.	
3. NAME OF DECEASED (Type or print) First FRANK Middle J. Last AUSTIN		4. DATE OF DEATH Month 9 Day 24 Year 1966	
5. SEX M	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-19-30 35 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY 7-Up Bottling Co.	9. AGE (In years last birthday) 35 yrs.
11. BIRTHPLACE (State or foreign country) Belle Glades Fla.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Austin		14. MOTHER'S MAIDEN NAME Thoebe Triester	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Nelphine Austin Address 202 North Frey St. Village Belle Glades			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured cervical spine DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fractured left femur and fracture dislocation right knee			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in auto involved in one-car accident.	
20c. TIME OF INJURY Month, Day, Year Hour 3 p.m. 9-24-66 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Delmar-Sharptown Rd. Delmar	20f. (City or town) (County) (State) Sussex Del.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer EXAMINER'S NAME (Type) Earl L. Royer, M.D. 409 Camden Ave., Salisbury, Md.		22. DATE SIGNED Sept. 26, 1966 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried	23b. DATE THEREOF 10-3-66	23c. NAME OF CEMETERY OR CREMATORY Shady Grove	23d. LOCATION (City or Town) (County) (State) Tampa Fla.
24. FUNERAL DIRECTOR Jolley Funeral Home, Salisbury, Md.		25a. REC'D BY REGISTRAR OCT 5 1966 25b. REGISTRAR'S SIGNATURE f Charles Judge	

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Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13391					13385				
1. PLACE OF DEATH a. COUNTY Wicomico					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Samuel		Middle S.		Last Barnes		4. DATE OF DEATH Month September 7 1966	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Nov. 11, 1893		9. AGE in years (last birthday) 72 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Somerset Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Samuel Barnes					14. MOTHER'S MAIDEN NAME Mary E. Howeth				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT George W. Barnes; Baltimore, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Sublethality of Heart DUE TO (b) Due to arteriosclerotic Deg. DUE TO (c) acute arteriosclerosis								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9/4, 1966, to 9/7, 1966, that (I) (we) last saw the deceased alive on 9/7, 1966, and that death occurred at 7:45 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Carter Hearn						22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) CARTER HEARN						22d. ADDRESS 226 N. Duane St.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/10/1966		23c. NAME OF CEMETERY OR CREMATORY Manokin Presbyterian		23d. LOCATION (City, town or county) Princess Anne, Md.			
24. FUNERAL DIRECTOR James Hearn						25a. REC'D BY REGISTRAR DATE SEP 14 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

13325

U.S. DEPARTMENT OF AGRICULTURE

13325

Wisconsin

Bellevue

Bellevue General Hospital

Nov. 11, 1933

Mr. [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
13386									
1. PLACE OF DEATH a. COUNTY Wicomico					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 20 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural-Pocomoke City			d. STREET ADDRESS R.F.D. 2	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Tabitha Middle F. Last Baylis					4. DATE OF DEATH Month September Day 4 Year 1966				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 28, 1880		9. AGE (In years last birthday) 86 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) Accomack County, Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thurgood Fisher					14. MOTHER'S MAIDEN NAME Tabitha Kelley				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs S. Francis Hall, Pocomoke City, Md.			Address R.F.D. 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro vascular thrombosis 4221 DUE TO (b) Arteriosclerotic CV. Disease DUE TO (c) --- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH 4 weeks Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Malnutrition Anemia Urinary Infection									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8/15/66 to 9/4/66 , that (I) (we) last saw the deceased alive on 9/3/66 , and that death occurred at 8:20 AM , from the causes and on the date stated above.									
22a. SIGNATURE [Signature]					22b. DATE SIGNED SEP 4 1966				
22c. PHYSICIAN'S NAME (Type) O. J. Burton M.D.					22d. ADDRESS Salisbury, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-6-1966		23c. NAME OF CEMETERY OR CREMATORY Nelson Cemetery			23d. LOCATION (City, town or county) (State) Worcester County, Md.		
24. FUNERAL DIRECTOR Robert H. Watson					25a. REC'D BY REGISTRAR SEP 8 1966				
ADDRESS Pocomoke City, Md.					25b. REGISTRAR'S SIGNATURE Charles Judge				

13328

13328

Woomioo

Salisbury

Feminale General Hospital

Woomioo

Salisbury

Woomioo

Salisbury

Cardio vascular disorders
Admission: CV Disease

Proteinuria
Hypertension
Unstable Angina

9/1/66
9/1/66

9/1/66
9/1/66

Salisbury, Maryland

Wojan Cemetery

Wojan Cemetery

Salisbury, Maryland

Salisbury, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury (Rural) 22-1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital					d. STREET ADDRESS R.D.#3 Morris Leonard Rd			e. IS RESIDENCE ON A FARM? Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) MARY FRANCES (MARIAN) MIDDLE					Last Bedsworth		4. DATE OF DEATH Month Sept Day 10 Year 1966			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 15/1933		9. AGE (In years last birthday) 33 yrs. IF UNDER 1 YEAR Months 5 Days 25 Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work at home				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Mardela (Wico. Co) Md.			12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Stanley Bedsworth					14. MOTHER'S MAIDEN NAME Sallie Messick					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)					16. SOCIAL SECURITY NO. R.D.#3 Salisbury, Maryland					17. INFIRMANT Mrs. Adelean Driscoll (Sister-In-Law) Address R.D.#3 Salisbury, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 545X sudden pulmonary embolus or aspiration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) complications of gastroenteritis									INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9/6/66 , 19__, to 9/10/66 , 19__, that (II) (we) last saw the deceased alive on 9/10 , 19__ 66 , and that death occurred at 6 PM , from the causes and on the date stated above.										
22a. SIGNATURE Fred N. Sugar					22b. DATE SIGNED 9/10/66			22c. PHYSICIAN'S NAME (Type) Fred N. Sugar		
22d. ADDRESS Peninsula Health Corp										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Sept. 13/1966		23c. NAME OF CEMETERY OR CREMATORY Bethol Church Cem.			23d. LOCATION (City, town or county) (State) Walston (Wicomico Co) Md.		
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY					ADDRESS SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR SEP 15 1966			
							25b. REGISTRAR'S SIGNATURE Charles Judge			

HOLLOWAY & COMPANY, BALTIMORE, MARYLAND
Sept. 13/1966 Bethel Church Cem. Watson (10000000) M.D.

Feb. 11, 1966

Mr. John Driscoll (Staver-In-Law)
R.D. 3, Salisbury, Maryland

Stanley Bedworth

House work at home

None

Marble (Waco Co.) M.D. U.S.A.

Calie Measick

Mar. 13/1966

2 25

247

R.D. 3, Route 1, Leonard Rd.

Peninsula General Hospital
Rm. 100 (Nathan)

Salisbury

Salisbury (M.D.)

Salisbury

Salisbury

10000000

10000000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13394					13388				
1. PLACE OF DEATH a. COUNTY Wicomico					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY W. ORCOSTER				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin			d. STREET ADDRESS 109 BROAD ST	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Guy E. Boston			4. DATE OF DEATH Month Day Year September 9 1966						
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT 17, 1888		9. AGE (In years last birthday) 77 yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POSTMASTER RET			10b. KIND OF BUSINESS OR INDUSTRY U.S. G.		11. BIRTHPLACE (County & State, or foreign country) BERLIN MD			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSIAH A. BOSTON					14. MOTHER'S MAIDEN NAME MATTIE PALMER				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 220-32-0845		17. INFORMANT Address Mrs. G.E. BOSTON BERLIN MD				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 4201 DUE TO (b) Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) ASCVD. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Emphysema									INTERVAL BETWEEN ONSET AND DEATH 48 hours
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 27 June , 19 66 , to 9 Sept , 19 66 , that (I) (we) last saw the deceased alive on 9 Sept , 19 66 , and that death occurred at 10:00 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Joseph C. Fitzgerald			22b. DATE SIGNED 9 September 66		22c. PHYSICIAN'S NAME (Type) Anna A. Burbage Berlin and				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 9/13/66		23c. NAME OF CEMETERY OR CREMATORY BUCKINGHAM		23d. LOCATION (City, town or county) (State) BERLIN W. OR. MD		
24. FUNERAL DIRECTOR Anna A. Burbage Berlin and			25a. REC'D BY REGISTRAR SEP 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge				

13384

CERTIFICATE OF DEATH

Alameda

Baltimore

Pennsylvania General Hospital

[Faint, mostly illegible text, likely a medical certificate or death record, containing names and dates.]

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH																													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																													
CERTIFICATE OF DEATH																													
13389																													
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Worcester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pocomoke City d. STREET ADDRESS Rt. 2, Box 337 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																								
3. NAME OF DECEASED (Type or print) First Walter Middle Boston Last Boston					4. DATE OF DEATH Month September Day 8 Year 1966																								
5. SEX Male					6. COLOR OR RACE Negro					7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>																			
8. DATE OF BIRTH Aug. 7, 1911					9. AGE (in years last birthday) 55					IF UNDER 1 YEAR Months 5 Days 5 Hours 55 Min. 55																			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer					10b. KIND OF BUSINESS OR INDUSTRY Factory					11. BIRTH PLACE (County & State, or foreign country) Md.					12. CITIZEN OF WHAT COUNTRY? U.S.A.														
13. FATHER'S NAME Frank Boston					14. MOTHER'S MAIDEN NAME Mary Beckett					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 219-14-2829					17. INFORMANT Mary Cropper Address Pocomoke City Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Gonorrhea, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) arteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH 1 yr										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. AGGIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from 9/3 , 19 66 , to 9/8 , 19 66 , that (I) (we) last saw the deceased alive on 9/8 , 19 66 , and that death occurred at 9:30 P.M. from the causes and on the date stated above.										22a. SIGNATURE David J. Blount 22c. PHYSICIAN'S NAME (Type) David J. Blount										22b. DATE SIGNED SEP 13 1966									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 9-13-66					23c. NAME OF GEMETERY OR CREMATORY St. James Cem.					23d. LOCATION (City, town or county) (State) Pocomoke City, Md.														
24. FUNERAL DIRECTOR Samuel Savage ADDRESS New Church, Va.					25a. REG'D BY REGISTRAR SEP 13 1966					25b. REGISTRAR'S SIGNATURE Charles Judge																			

13321

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH					
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
13396			13390		
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 8/18/1966 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine Bluff State Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels d. STREET ADDRESS Chew Ave. & Talbot St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) William Bottiger			4. DATE OF DEATH Month September Day 5 Year 1966		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Aug. 12, 1885		9. AGE (In years lost birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 8 Days 19 Hours 66 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) stone mason (retired)		12. KIND OF BUSINESS OR INDUSTRY		13. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
14. CITIZEN OF WHAT COUNTRY? U.S.A.		15. FATHER'S NAME George Washington Bottiger		16. MOTHER'S MAIDEN NAME Barbara Buettner	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		18. SOCIAL SECURITY NO. 218-10-4126		19. INFORMANT Records of Pine Bluff State Hospital, Salisbury, Maryland	
MEDICAL CERTIFICATION					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) 0021 (c) 0021 DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic vascular disease					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Salisbury		20g. (County) Talbot		20h. (State) Maryland	
21. I certify that (A) (this hospital) attended the deceased from Aug. 16 , 19 66 , to Sept. 5 , 19 66 , that (H) (we) last saw the deceased alive on Sept. 5 , 19 66 , and that death occurred at 12:42 PM from causes and on the date stated above.					
22a. SIGNATURE E. P. Ritchings		22b. DATE SIGNED Sept. 6, 1966		22c. PHYSICIAN'S NAME (Type) E. P. Ritchings, M.D.	
22d. ADDRESS Pine Bluff State Hospital, Salisbury, Maryland 21801		22e. MED. DIRECTOR <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 8 1966		23c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery	
23d. LOCATION (City or Town) St. Michael's		23e. (County) Talbot		23f. (State) Md	
24. FUNERAL DIRECTOR Harriet H. Harrison		24a. ADDRESS St. Michael's		24b. REC'D BY REGISTRAR SEP 9 1966	
24c. REGISTRAR'S SIGNATURE Charles Judge		24d. REGISTRAR'S SIGNATURE Charles Judge			

13300

RECORDS OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13397

CERTIFICATE OF DEATH

13391

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine Bluff State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Carlton Middle Grant Last Brown		4. DATE OF DEATH Month Sept. Day 15 Year 1966	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 4, 1904
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 15 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Operator		10b. KIND OF BUSINESS OR INDUSTRY Sharptown, Wicomico Co. Md.	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Brown		14. MOTHER'S MAIDEN NAME Martha Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-07-3946	
17. INFORMANT Records of Pine Bluff State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 1 , 19 66 , to Sept. 15 , 19 66 , that (I) (we) last saw the deceased alive on Sept. 15 , 19 66 , and that death occurred at 6:18 M, from causes and on the date stated above.			
22a. SIGNATURE E. P. Ritchings		22b. DATE SIGNED 9/15/66	
22c. PHYSICIAN'S NAME (Type) E. P. Ritchings		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 9-18-66	23c. NAME OF CEMETERY OR CREMATORY MT. SION CEMETERY	23d. LOCATION (City or Town) (County) (State) Sharptown Wicomico Md
24. FUNERAL DIRECTOR JAMES B. LASHIELL		25a. REC'D BY REGISTRAR EASTON, Md	
25b. REGISTRAR'S SIGNATURE SEP 21 1966		25c. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CENTINTE OF GRAIN

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THE UNITED STATES DEPARTMENT OF AGRICULTURE

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

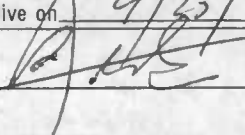
13398

CERTIFICATE OF DEATH

13392

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN TB		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				e. STREET ADDRESS Route 1, Hebron Md.				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Loney		First		Middle		Last BURRIS		4. DATE OF DEATH Month September Day 26 Year 1966	
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/17/1901		9. AGE (In years last birthday) yrs. 65	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Burris				14. MOTHER'S MAIDEN NAME Lala Mitchell					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214 16 4166		17. INFORMANT Address Ida Da hiell Salisbury, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive left ventricular failure. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 3 months Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Anasarcia								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9/25/66 , to 9/26/66 , that (I) (we) last saw the deceased alive on 9/25/66 and that death occurred at 9A M, from causes and on the date stated above.									
22a. SIGNATURE 				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Clinton F. Stewart				22d. ADDRESS Salisbury Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/29/66		23c. NAME OF CEMETERY OR CREMATORY Green Arces Cemetery		23d. LOCATION (City or Town) (County) (State) Salisbury Wicomico Md.			
24. FUNERAL DIRECTOR Clinton F. Stewart				ADDRESS Salisbury Md.		25a. RECD BY REGISTRAR DATE OCT 3 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
13393											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Mardela</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Mardela</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rt. #1, Athol</u>					d. STREET ADDRESS <u>Rt. #1, Athol</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>CLAYTON</u> Last <u>CALLOWAY</u>					4. DATE OF DEATH Month <u>September</u> Day <u>8</u> Year <u>1966</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 14, 1904</u>		9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>24</u> Hours <u></u> Min. <u></u> IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Athol, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William Edward Calloway</u>					14. MOTHER'S MAIDEN NAME <u>Nancy Ellen Truitt</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT Address <u>Mrs. Pauline J. Calloway (Wife)</u> <u>R.D. #1 (Athol), Mardela, Maryland</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CA</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CANCER LUNG.</u> DUE TO (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>N/A</u>								
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a.m. <u>19</u> p.m. <u></u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u></u> , 19 <u></u> , to <u></u> , 19 <u></u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>2:30</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Dr. Marcus D. Stephanides</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Sept. 8 / 1966</u>				
22c. PHYSICIAN'S NAME (Type) <u>Dr. Marcus D. Stephanides</u>					22d. ADDRESS <u>111 Davis St., Salisbury, Maryland</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 11, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mardela Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Mardela, Maryland</u>				
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>					25a. REC'D BY REGISTRAR <u>SEP 13 1966</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
13394										
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CHANCE d. STREET ADDRESS Box 29 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) HERBERT First E Middle Last CARELS					4. DATE OF DEATH September 7 1966 Month Day Year					
5. SEX MALE		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 13 1896		9. AGE (In years last birthday) 70 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRONIC		10b. KIND OF BUSINESS OR INDUSTRY ENGINEER		11. BIRTHPLACE (County & State, or foreign country) MOORESTOWN N.J.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME WILLIAM 16. SOCIAL SECURITY NO. 183-16-1810					14. MOTHER'S MAIDEN NAME EVA SHARPE 17. INFORMANT Mrs Margaret Thompson - TROY MAINE Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES N.W. I					18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Centralized Carcinomatosis (c) Carcinoma of pancreas PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9:5, 1966, to 9:7, 1966, that (I) (we) last saw the deceased alive on 9:0, 1966, and that death occurred at 6:30 AM, from the causes and on the date stated above.										
22a. SIGNATURE H. A. Briele					22b. DATE SIGNED 9:7-66			22c. PHYSICIAN'S NAME (Type) H. A. Briele		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF Sept 10-1966		23c. NAME OF CEMETERY OR CREMATORY Rock Creek		23d. LOCATION (City, town or county) (State) Salisbury Md.	
24. FUNERAL DIRECTOR Leroy Webster Princes Anne					25a. REC'D BY REGISTRAR DATE SEP 13 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13401
13395
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>210 West Main Street</u>	
3. NAME OF DECEASED (Type or print) First <u>ROGER</u> Middle <u>SAMUEL</u> Last <u>CAREY</u>		4. DATE OF DEATH Month <u>September</u> Day <u>18</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 28, 1902</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>11</u> Days <u>19</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffer (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chauffering</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Horace Edward Carey</u>		14. MOTHER'S MAIDEN NAME <u>Ocie Lambertson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown --</u>		16. SOCIAL SECURITY NO. <u>221-07-0123</u>	
17. INFORMANT <u>Mrs. Bernice J. Carey (Wife)</u> <u>210 W. Main Street, Salisbury, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis Heart Disease</u> 4200 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <u>coronary</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>N/A</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/15</u> , 19 <u>66</u> , to <u>9/18</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-18</u> , 19 <u>66</u> , and that death occurred at <u>4:20 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>W. B. Ellis, Jr.</u>		22b. DATE SIGNED <u>Sept. 17, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Wilbur R. Ellis, Jr.</u>		22d. ADDRESS <u>Medical Center, Salisbury, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept. 21, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 20 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN lb Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS Newton Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HELEN OTTO WALTON CATHELL		4. DATE OF DEATH Month SEPTEMBER Day 17 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 3, 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	9. AGE (In years last birthday) 72 yrs. IF UNDER 1 YEAR Months 7 Days 14 Hours -- Min. --
11. BIRTHPLACE (County & State, or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Morris Walton		14. MOTHER'S MAIDEN NAME Mattie McKinley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) --		16. SOCIAL SECURITY NO. --	
17. INFORMANT W. Walton Cathell (Son) 1506 Grey Court Ave., Richmond, Va. 22227		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/a	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. --	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-12, 1966 , to 9-17, 1966 , that (I) (we) last saw the deceased alive on 9-13, 1966 , and that death occurred at 3:15 A.M. from causes on and on the date stated above.			
22a. SIGNATURE Philip A. Insley		22b. DATE SIGNED Sept. 19-1966	
22c. PHYSICIAN'S NAME (Type) Dr. Philip A. Insley		22d. ADDRESS Main Street, Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 19, 1966	23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR SEP 22 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13800

CERTIFICATE OF DEATH

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Isabel L. Anderson

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13403

CERTIFICATE OF DEATH

13397

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 19-2 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Somerset c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Vernon, Md. d. STREET ADDRESS R. F. D. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lucy Blanche Causey		4. DATE OF DEATH Month Day Year September 26 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 23, 1890
9. AGE (If years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (County & State, or foreign country) Solomons Island, Md.		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Joseph Bailey		14. MOTHER'S MAIDEN NAME Laura Bailey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 1532	
17. INFORMANT Harry Causey, Princess Anne, Md.		Address R. F. D. 1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-26 , 19 66 , to 9-26 , 19 66 , that (I) (we) last saw the deceased alive on 9-26 , 19 66 , and that death occurred at 12:30 M, from causes and on the date stated above.			
22a. SIGNATURE H. H. Briele		22b. DATE SIGNED 9-30-66	
22c. PHYSICIAN'S NAME (Type) H. H. Briele		22d. ADDRESS Medical Center Salisbury Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/29/66	
23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		23d. LOCATION (City or Town) (County) (State) Mt. Vernon, Som., Md.	
24. FUNERAL DIRECTOR Lavin R. Wilson, Princess Anne, Md.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 3 1966	

1937

CERTIFICATE OF DEATH

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FOR STATE HEALTH DEPT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13398

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural)		c. LENGTH OF STAY IN lb 22-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naylor Mill Road		d. STREET ADDRESS Northwood Drive	
3. NAME OF DECEASED (Type or print) First Middle Last VERNON OLIVER CROCKETT		4. DATE OF DEATH Month Day Year SEPT. 8 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27, 1903
9. AGE (In years lost birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 5 7	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trash Collector		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph S. Crockett		14. MOTHER'S MAIDEN NAME Sarah Margaret Guy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No --		16. SOCIAL SECURITY NO. 214-10-7721	
17. INFORMANT Mrs. Marie E. Jenkins (Sister) Address Locustville, Virginia 23404		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Atherosclerosis DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Philip A. Insley EXAMINER'S NAME (Type) Dr. Philip A. Insley		22. DATE SIGNED 9-4-66 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 8, 1966	
23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City or Town) (County) (State) Salisbury, Wic. Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR SEP 8 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13405					13399				
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pittsville d. STREET ADDRESS ✓ e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last William Clyde DAVIS			4. DATE OF DEATH Month Day Year SEPTEMBER 5 1966		5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH MAY 8, 1895 9. AGE (In years last birthday) 71 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Gendy Hall						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ✓			16. SOCIAL SECURITY NO. 216-18-2251		17. INFORMANT Pedger Davis Pittsville Md. Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5020 Cerebral Anoxia DUE TO Chronic Cor Pulmonale (b) Chronic Bronchitis + Emphysema. (c) 2 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 2 weeks Years								INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 8/2/66 to 9/5/66 , that (I) (we) last saw the deceased alive on 9/4/66 , and that death occurred at 4:30 PM , from the causes and on the date stated above.									
22a. SIGNATURE [Signature]					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) [Signature]					22d. ADDRESS [Signature]				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 9/8/66		23c. NAME OF CEMETERY OR CREMATORY Lewis		23d. LOCATION (City, town or county) (State) Willards, Md.		
24. FUNERAL DIRECTOR Felix Thaly Salisbury, Md.					25a. REC'D BY REGISTRAR SEP 9 1966		25b. REGISTRAR'S SIGNATURE [Signature]		

13389

CERTIFICATE OF DEATH

Wisconsin

Sanitary

Pennsylvania General Hospital

Paris

May 1st 11

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City of Paris

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
Item 1d Film 3501 10/21/66 md													
1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Wicomico</i>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>				c. LENGTH OF STAY in 1b <i>17 mos</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury Md. 221</i>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>124 First St.</i>						d. STREET ADDRESS <i>112 First St.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Della Mae Flow</i>			First Middle Last			4. DATE OF DEATH Month Day Year <i>9 30 1966</i>							
5. SEX <i>F</i>		6. COLOR OR RACE <i>negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8-15-1924</i>		9. AGE (In years last birthday) <i>42 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>laborer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>laborer</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Winston Salem N.C.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>Harom Flow</i>						14. MOTHER'S MAIDEN NAME <i>Lola Little</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Alene Flow - Panticoke, Md.</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive Cerebral Hemorrhage</i> DUE TO (b) <i>Hypertension</i> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
19. INTERVAL BETWEEN ONSET AND DEATH <i>14+</i>													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>													
MEDICAL CERTIFICATION													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>1 Sept 1965</i> to <i>30 Sept 1966</i> , that (I) (we) last saw the deceased alive on <i>30 Sept 1966</i> , and that death occurred at <i>10 PM</i> from the causes and on the date stated above.													
22a. SIGNATURE <i>E. A. Farnell</i>												22b. DATE SIGNED <i>5 Oct 66</i>	
22c. PHYSICIAN'S NAME (Type) <i>E. A. Farnell, MD</i>				22d. ADDRESS <i>652 W. Main St., Salisbury, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>				23b. DATE THEREOF <i>10-5-66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Salisbury Methodist</i>		23d. LOCATION (City, town or county) (State) <i>Panticoke - Wic. Md.</i>					
24. FUNERAL DIRECTOR <i>Harriet Jolley Jersey</i>						ADDRESS <i>Salisbury, Md.</i>		25a. REC'D BY REGISTRAR <i>DATE OCT 11 1966</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Jones</i>			

11/24/41

10/21/41



CERTIFICATE OF DEATH

13407

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 27 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hope Middle Halo Last Foskey		4. DATE OF DEATH Month 9 Day 18 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 16, 1905
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 4 Days 2 Hours 2 Min.	11. IF UNDER 24 HRS. Hours 2 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor (Seamstress)		10b. KIND OF BUSINESS OR INDUSTRY Tailoring	
11. BIRTHPLACE (County & State, or foreign country) La Grange, Indiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harvey H. Holden		14. MOTHER'S MAIDEN NAME Wava B. Mingis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-16-9990	
17. INFORMANT Mr. Milton M. Holden (Brother)		Address 708 N. Washington Street, Easton, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Advanced CA of the right lung with metastasis to cervical glands. DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 11 Mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/22 , 19 66 , to 9/18 , 19 66 , that (I) (we) last saw the deceased alive on 9/18 , 19 66 , and that death occurred at 5:05 A.M. , from causes on and on the date stated above.			
22a. SIGNATURE L. V. Maldve		22b. DATE SIGNED 9/19/66	
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 21, 1966	23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25. REC'D BY REGISTRAR DATE SEP 22 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

11156

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13408					13402				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		a. STATE			b. COUNTY	
Wicomico			Salisbury		Maryland			Wicomico	
c. LENGTH OF STAY IN 1b			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS	
			Peninsula General Hospital		Salisbury			403 Newton Terrace	
3. NAME OF DECEASED (Type or print)			First Middle Last		4. DATE OF DEATH			Month Day Year	
LISA ANNE GLADDEN					September 26 1966				
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Baby DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.	
Female		White				Sept. 24, 1966		0 yrs. 0 Months 2 Days 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?	
none			--		Salisbury, Maryland			USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Roy Walter Gladden					Brenda Frances Phippin				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Address				
no			--		Mr. & Mrs. Roy W. Gladden, 403 Newton Terrace, Salisbury, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 774X Premature - 2 lb immature infant									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
				N/A					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19									
21. I certify that (I) (this hospital) attended the deceased from Sept 24, 1966, to Sept 26, 1966, that (I) (we) last saw the deceased alive on Sept 26 1966, and that death occurred at 2:25 M, from the causes and on the date stated above.									
22a. SIGNATURE								22b. DATE SIGNED	
William C. Morgan								Sept. 27/1966	
22c. PHYSICIAN'S NAME (Type)								22d. ADDRESS	
Dr. William C. Morgan								Medical Center, Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		
Burial			Sept. 28, 1966		Parsons Cemetery		Salisbury, Maryland		
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
HOLLOWAY & COMPANY, SALISBURY, MARYLAND					DATE SEP 30 1966		Charles Judge		

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OFFICE OF THE ATTORNEY GENERAL

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY WICOMICO MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manokin	
c. LENGTH OF STAY IN lb 2 days		d. STREET ADDRESS --	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DEER'S HEAD STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle EDWIN Last GREEN		4. DATE OF DEATH Month September Day 8 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 15, 1885
9. AGE (In years lost birthdays) 81 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SALEMAN		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MARION, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS JEFFERSON GREEN		14. MOTHER'S MAIDEN NAME VIRGINIA GRAVIN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 212-10-6433	
17. INFORMANT MRS. MARIE GREEN		Address MANOKIN, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Cerebral vascular accident DUE TO (c) 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH ? Aug. 1966
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/> 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept. 6, 1966 to Sept. 8, 1966 , that (I) (we) last saw the deceased alive on Sept. 8, 1966 , and that death occurred at 1:10 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Andrew C Mitchell</i>		22b. DATE SIGNED 9/8/66	
22c. PHYSICIAN'S NAME (Type) A. C. Mitchell, M. D.		22d. ADDRESS Deer's Head State Hosp., Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 9/12/1966	23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State) GLEN BURNIE, MD.
24. FUNERAL DIRECTOR LEVIN R. WILSON		25a. REC'D BY REGISTRAR SEP 14 1966	
ADDRESS PRINCESS ANNE, MD.		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DEPARTMENT OF DEFENSE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md. b. COUNTY Somerset c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RFD Princess Anne d. STREET ADDRESS RFD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Annie R. Hall First Middle Last 4. DATE OF DEATH September 9 1966 Month Day Year						5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Feb 25, 1884 82 yrs. 9. AGE (in years last birthday) 82 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Somerset Co., Md 12. CITIZEN OF WHAT COUNTRY? US						13. FATHER'S NAME George Noble 14. MOTHER'S MAIDEN NAME Rebecca Price					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT George Hall Address Monie Md.						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201 DUE TO (b) Coronary Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Sept 9, 1966 , to Sept 9, 1966 , that (I) (we) last saw the deceased alive on Sept 9, 1966 , and that death occurred at 4:15 P.M. from the causes and on the date stated above.											
22a. SIGNATURE 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) James H. Hannon 22d. ADDRESS Princess Anne Md.						23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 9/11/1966 23c. NAME OF CEMETERY OR CREMATORY Beechwood 23d. LOCATION (City, town or county) (State) Princess Anne Md.					
24. FUNERAL DIRECTOR James Hannon 25a. REC'D BY REGISTRAR SEP 13 1966 25b. REGISTRAR'S SIGNATURE Charles Judge											

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CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 4910 North 25th St.	
3. NAME OF DECEASED (Type or print) Richard M. HAMM		4. DATE OF DEATH Month 9 Day 4 Year 1966	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 13, 1945
9. AGE (In years lost birthday) 20 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY ARMED FORCES	
11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clark William Hamm		14. MOTHER'S MAIDEN NAME Edith Embrey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Viet Nam Dec. 65 to Aug. 66		16. SOCIAL SECURITY NO 231 58 4584	
17. INFORMANT Mr. Clark William Hamm, 4910 North 25th St., Arlington, Va.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured neck DUE TO (b) 8254 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Single car auto accident	
20c. TIME OF INJURY Month, Day, Year 3:00 p.m. 9-4-66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.) Route 50		20f. (City or town) (County) (State) Vienna Va. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Philip A Insley		M.D.	
EXAMINER'S NAME (Type) Philip A Insley		22. DATE SIGNED 9-4-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-9-1966	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington, Virginia		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR W W Chambers		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE SEP 8 1966	

U.S. Navy

FROM 1/65

FROM 1/65

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1. PLACE OF DEATH a. COUNTY <div style="border: 1px solid black; padding: 2px; text-align: center;">Wicomico</div> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <div style="border: 1px solid black; padding: 2px; text-align: center;">Salisbury</div> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <div style="border: 1px solid black; padding: 2px; text-align: center;">Peninsula General Hospital</div>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <div style="border: 1px solid black; padding: 2px; text-align: center;">Maryland</div> b. COUNTY <div style="border: 1px solid black; padding: 2px; text-align: center;">Wicomico</div> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="border: 1px solid black; padding: 2px; text-align: center;">Salisbury</div> d. STREET ADDRESS <div style="border: 1px solid black; padding: 2px; text-align: center;">119 Naylor Street</div>	
3. NAME OF DECEASED <div style="display: flex; justify-content: space-between;"> <div>First <div style="border: 1px solid black; padding: 2px; text-align: center;">Winfield</div></div> <div>Middle <div style="border: 1px solid black; padding: 2px; text-align: center;">Scott</div></div> <div>Last <div style="border: 1px solid black; padding: 2px; text-align: center;">HANCOCK</div></div> </div>		4. DATE OF DEATH <div style="display: flex; justify-content: space-between;"> <div>Month <div style="border: 1px solid black; padding: 2px; text-align: center;">September</div></div> <div>Day <div style="border: 1px solid black; padding: 2px; text-align: center;">12</div></div> <div>Year <div style="border: 1px solid black; padding: 2px; text-align: center;">1966</div></div> </div>	
5. SEX <div style="border: 1px solid black; padding: 2px; text-align: center;">MALE</div>		6. COLOR OR RACE <div style="border: 1px solid black; padding: 2px; text-align: center;">WHITE</div>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <div style="border: 1px solid black; padding: 2px; text-align: center;">May 2, 1882</div>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="border: 1px solid black; padding: 2px; text-align: center;">Retired - Fed. Commander</div>		9b. KIND OF BUSINESS OR INDUSTRY 	
10a. BIRTHPLACE (County & State, or foreign country) <div style="border: 1px solid black; padding: 2px; text-align: center;">Salisbury, Maryland</div>		10b. CITIZEN OF WHAT COUNTRY? <div style="border: 1px solid black; padding: 2px; text-align: center;">USA</div>	
11. FATHER'S NAME <div style="border: 1px solid black; padding: 2px; text-align: center;">George Hancock</div>		12. MOTHER'S MAIDEN NAME <div style="border: 1px solid black; padding: 2px; text-align: center;">Aorelia Phippin</div>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <div style="border: 1px solid black; padding: 2px; text-align: center;">No</div>		14. SOCIAL SECURITY NO. <div style="border: 1px solid black; padding: 2px; text-align: center;">214-28-3570</div>	
15. INFORMANT <div style="border: 1px solid black; padding: 2px; text-align: center;">Mrs. Ola D. Hancock (Wife)</div>		16. ADDRESS <div style="border: 1px solid black; padding: 2px; text-align: center;">119 Naylor Street, Salisbury, Maryland</div>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 2px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <div style="border: 1px solid black; padding: 2px; text-align: center;">myocardial infarction</div> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <div style="border: 1px solid black; padding: 2px; text-align: center;">generalized arteriosclerosis</div>			
18a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <div style="border: 1px solid black; padding: 2px; text-align: center;">N/A</div>	
19a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <div style="border: 1px solid black; padding: 2px; text-align: center;">19</div>		19b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
19c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		19d. (City or town) (County) (State) 	
20. I certify that (I) (this hospital) attended the deceased from <div style="border: 1px solid black; padding: 2px; text-align: center;">Apr. 1966</div> to <div style="border: 1px solid black; padding: 2px; text-align: center;">9/12</div> 1966 , that (I) (we) last saw the deceased alive on <div style="border: 1px solid black; padding: 2px; text-align: center;">9/12</div> 1966 , and that death occurred at <div style="border: 1px solid black; padding: 2px; text-align: center;">10:30</div> P.M. , from the causes and on the date stated above.			
21. SIGNATURE <div style="border: 1px solid black; padding: 2px; text-align: center;">Dr. E. M. Beardsley</div>		22. DATE SIGNED <div style="border: 1px solid black; padding: 2px; text-align: center;">Sept. 14 / 1966</div>	
23. PHYSICIAN'S NAME (Type) <div style="border: 1px solid black; padding: 2px; text-align: center;">Dr. E. M. Beardsley</div>		24. ADDRESS <div style="border: 1px solid black; padding: 2px; text-align: center;">207 Maryland Ave., Salisbury, Maryland</div>	
25a. BURIAL, CREMATION, REMOVAL (Specify) <div style="border: 1px solid black; padding: 2px; text-align: center;">Burial</div>		25b. DATE THEREOF <div style="border: 1px solid black; padding: 2px; text-align: center;">Sept. 15, 1966</div>	
25c. NAME OF CEMETERY OR CREMATORY <div style="border: 1px solid black; padding: 2px; text-align: center;">Wicomico Memorial Park</div>		25d. LOCATION (City, town or county) (State) <div style="border: 1px solid black; padding: 2px; text-align: center;">Salisbury, Maryland</div>	
26. FUNERAL DIRECTOR <div style="border: 1px solid black; padding: 2px; text-align: center;">HOLLOWAY & COMPANY, SALISBURY, MARYLAND</div>		27. REC'D BY REGISTRAR <div style="border: 1px solid black; padding: 2px; text-align: center;">SEP 15 1966</div>	
28. REGISTRAR'S SIGNATURE <div style="border: 1px solid black; padding: 2px; text-align: center;">f Charles Judge</div>			

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Belknap's General Hospital

Belknap's General Hospital

Belknap's General Hospital

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DELA</u> b. COUNTY <u>SUSSEX</u> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Georgetown</u> d. STREET ADDRESS <u>112 KIMMEY ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>Charles H. Harris</u>			First Middle Last		4. DATE OF DEATH <u>September 10 1966</u>		Month Day Year				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>28 DEC 1884</u>		9. AGE (in years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET RAILROAD</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>R.R.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>SUSSEX, DELA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>GEORGE HARRIS</u>					14. MOTHER'S MAIDEN NAME <u>RACHAEL DONOVAN</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>716-01-721A</u>		17. INFORMANT <u>Beatrice PIZZAIN</u>		Address <u>Bethel Dela.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASCVD. generalized</u> 4221 DUE TO <u>decompensated</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia 2 to 3 to Bicuspid Aortic Hypertrophy</u>										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>8-2-66</u> , 19 <u>66</u> , to <u>9-10-66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-10-66</u> , 19 <u>66</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Dr. C. Fitzgerald</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10 September 1966</u>				
22c. PHYSICIAN'S NAME (Type) <u>R. F. Nodda</u>					22d. ADDRESS <u>Medical Center Salisbury, Maryland</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>14th SEP 66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>UNION</u>		23d. LOCATION (City, town or county) (State) <u>Georgetown Dela.</u>					
24. FUNERAL DIRECTOR <u>R. F. Nodda</u>					ADDRESS <u>Georgetown Dela.</u>		25a. REC'D BY REGISTRAR <u>SEP 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

R.F. Hall Georgetown Dela
14th Street Union

Georgetown Dela

THE CI-101A Machine Printer Better Bldg.
Ranger Gordon
R.R. 12
38 Dec 1897 81

115 KIMMEY ST

Georgetown

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
13414					13408				
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wicomico County Nursing Home					d. STREET ADDRESS 104 W. Isabella St			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle VIRGINIA Last HEARING					4. DATE OF DEATH Month SEPT. Day 15 Year 1966				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 10/1869		9. AGE (In years last birthday) 96 yrs. IF UNDER 1 YEAR Months 10 Days 05 IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Maryland, Port Deposit			12. CITIZEN OF WHAT COUNTRY U S A	
13. FATHER'S NAME GEORGE MOHRLEIN					14. MOTHER'S MAIDEN NAME Sophia Sisztler				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 220-52-7936		17. INFORMANT Address Mrs. Clay L. Hentschel (Daughter) (Same as Item #2 above)				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ 4200								INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Arteriosclerosis; Aneurysm of Aorta								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8/16 , 19 66 , to 9/15 , 19 66 , that (I) (we) last saw the deceased alive on 9/15 , 19 66 , and that death occurred at 10 A M, from the causes and on the date stated above.									
22a. SIGNATURE David J. Gilmore					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. Sept. 15/1966			22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. David J. Gilmore					22d. ADDRESS Medical Center Salisbury, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 17 /66		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery			23d. LOCATION (City, town or county) (State) Woodlawn, Md.		
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY SALISBURY, MARYLAND				ADDRESS		25a. REC'D BY REGISTRAR SEP 19 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

13408

CERTIFICATE OF DEATH

Wicomico

Maryland

Wicomico

Salisbury

Salisbury

100 W. Isabelle St

Wicomico County Nursing Home

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SEPT.

HEARING

VIRGINIA

MALE

Nov. 10/1969 35 10 05

Female white

Maryland

Home

None

UNKNOWN MONTGOMERY

Mr. Clay L. Henderson (Deceased)
220-52-7396 (same as item 2 above)

Aug: 1969

Sept. 1969

Medical Center Salisbury, Maryland

Dr. David J. Gilmore

Dr. David J. Gilmore

HOLLAND & COMPANY SALISBURY, MARYLAND

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13409

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balt. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allen Road		d. STREET ADDRESS 500 S. Beachfield Ave.	
3. NAME OF DECEASED (Type or print) First MARTHA Middle MARGERET Last HERZING		4. DATE OF DEATH Month SEPT. Day 4th Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26/1927
9. AGE (In years last birthday) 39 yrs.		10. IF UNDER 1 YEAR Months 3 Days 4 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Reg. Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William L. Herzing		14. MOTHER'S MAIDEN NAME Martha M. Bentz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT (Same as above - Item #2) Phone - 644-0808	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound Fracture Skull DUE TO 8234 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car - ran off road + hit tree	
20c. TIME OF INJURY Month, Day, Year April 4:00 PM 9/4 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Wicomico County, Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. Philip A. Ansley		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Main St. Salisbury, Maryland		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED Sept 4 / 1966		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/8/66	
23c. NAME OF CEMETERY OR CREMATORY ENTOMBMENT, LORRAINE		23d. LOCATION (City or Town) (County) (State) BALTO. CO. MD.	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY		25a. REC'D BY REGISTRAR SEP 7 1966	
ADDRESS SALISBURY, MARYLAND		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13416

13410

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS Rt.#1, Meadow Bridge Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LEE Middle ROY Last HITCH				4. DATE OF DEATH Month September Day 23 Year 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 28, 1914	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 4 Days 25 Hours Min. 		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Poultry Dealer		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	
11. BIRTHPLACE (County & State, or foreign country) North Carolina				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Thomas Hitch				14. MOTHER'S MAIDEN NAME Elnora McGrath			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --		17. INFORMANT Address Mrs. Elizabeth S. Hitch (Wife), Rt. 1 Meadow Bridge Rd., Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, aspiration 163X Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Carcinoma of lung (c) 						INTERVAL BETWEEN ONSET AND DEATH 1 hr 1 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that (I) (this hospital) attended the deceased from 9-13 , 19 66 to 9-17 , 19 66 , that (I) (we) last saw the deceased alive on 9-13 , 19 66 , and that death occurred at 10:40 M. from the causes and on the date stated above.							
22a. SIGNATURE Dr. Nevins W. Todd, Jr.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Sept. 26 / 1966	
22c. PHYSICIAN'S NAME (Type) Dr. Nevins W. Todd, Jr.				22d. ADDRESS Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 27, 1966		23c. NAME OF CEMETERY OR CREMATORY Zion Cemetery		23d. LOCATION (City, town or county) (State) Somerset County, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR DATE SEP 27 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

01161

RECEIVED



CERTIFICATE OF DEATH

13417

13411

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 23 2		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS R.F.D. e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEROME MARTIE HOLLOWAY		4. DATE OF DEATH Month SEPTEMBER Day 29 Year 1966	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 2, 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY SELF EMP.	9. AGE (In years last birthday) 78 yrs.
11. BIRTHPLACE (County & State, or foreign country) BERLIN MD		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME MARTIE HOLLOWAY		14. MOTHER'S MAIDEN NAME JULIA JOHNSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT Mrs. J. M. Holloway		Address BERLIN MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Intracerebral hemorrhage DUE TO (b) Cerebral atherosclerosis DUE TO (c) 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 10 days Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypostatic pneumonia, terminal			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-18 , 19 66 to 9-29 , 19 66 that (I) (we) last saw the deceased alive on 9-28 , 19 66 , and that death occurred at 2:45 P.M. from causes and on the date stated above.			
22a. SIGNATURE Robert R. White, Jr.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 9-30-66
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10/1/66	23c. NAME OF CEMETERY OR CREMATORY EVERGREEN	23d. LOCATION (City or Town) (County) (State) BERLIN WOR. MD
24. FUNERAL DIRECTOR Anna B. Burbage		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 4 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11461

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1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in a vault within 72 hours after death.

13418

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13412

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 23-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Peninsula General Hospital		d. STREET ADDRESS Labor Camp	
3. NAME OF DECEASED (Type or print) First ALBERT Middle JOHNSON Last JOHNSON		4. DATE OF DEATH Month 9 Day 27 Year 1966	
5. SEX M	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unk
9. AGE (In years lost birthday) 51 Yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk		10b. KIND OF BUSINESS OR INDUSTRY Unk	
11. BIRTHPLACE (State or foreign country) Unk		12. CITIZEN OF WHAT COUNTRY? Unk	
13. FATHER'S NAME Unk		14. MOTHER'S MAIDEN NAME Unk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO. Unk	
17. INFORMANT Pen. Gen. Hosp. Salisbury, Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Carl L. Royer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) Sept. 29, 1966	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 10/3/66	23c. NAME OF CEMETERY OR CREMATORY Annapolitan Road	23d. LOCATION (City or town) (County) (State) Baltimore Md
24. FUNERAL DIRECTOR Barker M. West		25a. REC'D BY REGISTRAR DATE OCT 5 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

1948

Handwritten signature

CERTIFICATE OF DEATH

13413

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 8726966	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		d. STREET ADDRESS 1100 Mace's Lane	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine Bluff State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louis Middle Alvin Last Kiah		4. DATE OF DEATH Month September Day 27 Year 1966	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1907
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Kiah		14. MOTHER'S MAIDEN NAME Julia Myster	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-07-9156	
17. INFORMANT Records of Pine Bluff State Hospital, Salisbury, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 0021			INTERVAL BETWEEN ONSET AND DEATH 7 weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from August 29, 1966 , to Sept. 27, 1966 that (X) (we) lost saw the deceased alive on Sept. 27, 1966 , and that death occurred at 11:50 AM from causes and on the date stated above.			
22a. SIGNATURE E. P. Ritchings		22b. DATE SIGNED Sept. 27, 1966	
22c. PHYSICIAN'S NAME (Type) E. P. Ritchings, M.D.		22d. ADDRESS Pine Bluff State Hospital Salisbury, Maryland - 21801	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/1/66	23c. NAME OF CEMETERY OR CREMATORY Bethel	23d. LOCATION (City or Town) (County) (State) Cambridge Dor. Md.
24. FUNERAL DIRECTOR Frederick C. Peltier		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 5 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
13420					13414														
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)														
a. COUNTY Wicomico MARYLAND					a. STATE Maryland b. COUNTY Worcester														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whaleyville														
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital					d. STREET ADDRESS 232														
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH														
First Middle Last HORACE E. LEWIS					Month Day Year SEPTEMBER 10 19 66														
5. SEX MALE					6. COLOR OR RACE WHITE														
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH Feb. 19, 1909														
9. AGE (In years last birthday) 57 yrs.					10. IF UNDER 1 YEAR Months Days Hours Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Poultryman					10b. KIND OF BUSINESS OR INDUSTRY Own Farm														
11. BIRTHPLACE (County & State, or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? USA														
13. FATHER'S NAME Thomas Lewis					14. MOTHER'S MAIDEN NAME Ella Baker														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) xx xx					16. SOCIAL SECURITY NO. 220-10-9814														
17. INFORMANT Rada Lewis					Address Whaleyville, Md.														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 445X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malignant Hypertension DUE TO (c) Heart Failure										INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Bronchiectasis + pulm. insufficiency										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from June , 1966, to 10 Sept , 1966, that (I) (we) last saw the deceased alive on 10 Sept 1966, and that death occurred at 1:30 M, from the causes and on the date stated above.										22a. SIGNATURE Joseph T. Seared									
22b. DATE SIGNED 10 Sept 66										22c. PHYSICIAN'S NAME (Type) Medical Center, Salisbury, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE THEREOF 9/13/66									
23c. NAME OF CEMETERY OR CREMATORY Dale										23d. LOCATION (City, town or county) (State) Whaleyville, Md.									
24. FUNERAL DIRECTOR Robert Whaley										25a. REC'D BY REGISTRAR SEP 14 1966									
25b. REGISTRAR'S SIGNATURE Charles Judge																			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
13421														
1. PLACE OF DEATH a. COUNTY Wicomico					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury					b. COUNTY Worcester									
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ocean City									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital					d. STREET ADDRESS 106 Philadelphia Avenue									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>														
3. NAME OF DECEASED (Type or print) First Middle Last Jody Lynn Lewis					4. DATE OF DEATH Month Day Year September 8 1966									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 8/1966		9. AGE (In years last birthday) yrs. Months Days 2 27						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Wicomico Co., Md.			12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME Robert Thomas Lewis					14. MOTHER'S MAIDEN NAME Charlotte C. Wenger									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Robert T. Lewis Ocean City Md									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perinatal Hypoxia (Asphyxia 1 min) 7620 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) exact cause undetermined DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple congenital anomalies 1) microcephaly 2) web neck 3) bilateral renal hypoplasia INTERVAL BETWEEN ONSET AND DEATH approx 3 hrs														
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)														
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I of Part II of Item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						
20f. (City or town) (County) (State)			20g. (City or town) (County) (State)			20h. (City or town) (County) (State)			20i. (City or town) (County) (State)					
21. I certify that (1) (this hospital) attended the deceased from 9/8, 1966, to 9/8, 1966, that (1) (we) last saw the deceased alive on 9/8, 1966, and that death occurred at 9:25 PM, from the causes and on the date stated above.														
22a. SIGNATURE Alfred C. Koles					22b. DATE SIGNED 9/9/66									
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS Medical Center - Salisbury, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 9/10/66		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN			23d. LOCATION (City, town or county) (State) Beech WOOD MD						
24. FUNERAL DIRECTOR Anna A. Burbage Berlin Md					25a. REC'D BY REGISTRAR DATE SEP 13 1966					25b. REGISTRAR'S SIGNATURE Charles Judge				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13422					13416				
1. PLACE OF DEATH a. COUNTY Wicomico					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela (Athol) 22-1				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rt. #1					d. STREET ADDRESS Rt. #1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First MANOLIA		Middle ISABELLE		Last LLOYD		4. DATE OF DEATH Month September 22 Day 22 Year 1966	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 30, 1889		9. AGE (In years last birthday) 77 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 5 Days 22 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY --			11. BIRTHPLACE (County & State, or foreign country) Athol, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Robert Majors					14. MOTHER'S MAIDEN NAME Alberta Bradley				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 219-07-7040		17. INFORMANT Mr. Edward L. Lloyd (Husband) Rt. #1, Athol, Mardela, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4344 Heart Distention (b) Over work and (c) malnutrition Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Asplenic intestinal + hernia 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> N/A 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that death occurred at 9 A.M. from the causes and on the date stated above.									
22a. SIGNATURE Fred C. Quinn					22b. DATE SIGNED Sept. 23 / 1966			22c. PHYSICIAN'S NAME (Type) Dr. Fred C. Quinn	
22d. ADDRESS Mardela, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 25, 1966		23c. NAME OF CEMETERY OR CREMATORY Mardela Cemetery			23d. LOCATION (City, town or county) (State) Mardela, Maryland		
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND					25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 26 1966 f Charles Judge				

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS Delaware Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Sarah Elizabeth Long		4. DATE OF DEATH September 17 1966		5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-1-03		9. AGE (In years lost birthday) 62 YRS.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Wicomico		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Stemons Johnson		14. MOTHER'S MAIDEN NAME Lula Horsey		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Roscoe Long - Delaware Ave. Salisbury			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		19. INTERVAL BETWEEN ONSET AND DEATH 3 d		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-14 , 19 66 , to 9-17 , 19 66 , that (II) (we) last saw the deceased alive on 9-17 , 19 66 , and that death occurred at 11:50 AM , from causes and on the date stated above.		22a. SIGNATURE W. R. Ellis, Jr.		22b. DATE SIGNED 9-17-66		22c. PHYSICIAN'S NAME (Type) W. R. Ellis, Jr.		22d. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-21-66		23c. NAME OF CEMETERY OR CREMATORY Green Acres Mem. Pk.		23d. LOCATION (City or Town) (County) (State) Salisbury Wico Maryland			
24. FUNERAL DIRECTOR Loretta B. Jolley - Jersey Rd. Rt #2 Salis.		25a. REC'D BY REGISTRAR SEP 26 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE		25d. REGISTRAR'S SIGNATURE		25e. DATE		25f. REGISTRAR'S SIGNATURE		25g. DATE		25h. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECORDS OF DEATH

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CERTIFICATE OF DEATH

13418

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b Since 8/17/66	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dames Quarter		19-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine Bluff State Hospital		d. STREET ADDRESS Main Rd	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Melvin Middle Earl Last Messick		4. DATE OF DEATH Month Sept. Day 1 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/27/1907
9. AGE (In years lost birthday) 58 yrs.		IF UNDER 1 YEAR Months 58 Days 58	IF UNDER 24 HRS. Hours 58 Min. 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Somerset Co., Md.
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Robert Messick		14. MOTHER'S MAIDEN NAME Mary Messick	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records of Pine Bluff State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Pulmonary Tuberculosis DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug. 17 , 19 66 , to Sept. 1 , 19 66 that (I) (we) last saw the deceased alive on Sept. 1 19 66 and that death occurred at 9:47 p.m. from causes and on the date stated above.			
22a. SIGNATURE E. P. Ritchings		22b. DATE SIGNED 9/2/66	
22c. PHYSICIAN'S NAME (Type) E. P. Ritchings, M.D.		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/4/66	23c. NAME OF CEMETERY OR CREMATORY Messick Cemetery	23d. LOCATION (City or Town) (County) (State) Dames Quarter Md
24. FUNERAL DIRECTOR Larry Webster		25a. REC'D BY REGISTRAR Princess Anne MD	
25b. REGISTRAR'S SIGNATURE SEP 6 1966		25c. DATE SEP 6 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF TEXAS

1941

County of _____ State of Texas

Know all men by these presents, _____

for and in consideration of the sum of _____ Dollars

to _____ the receipt of which is hereby acknowledged

that _____

do hereby certify that _____

is the true and correct copy of the original

as the same appears from the records of the _____

County of _____ State of Texas

and that the same is a true and correct copy of the original

as the same appears from the records of the _____

County of _____ State of Texas

and that the same is a true and correct copy of the original

as the same appears from the records of the _____

County of _____ State of Texas

and that the same is a true and correct copy of the original

as the same appears from the records of the _____

County of _____ State of Texas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>					d. STREET ADDRESS <u>212 Davis Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last (Lula) <u>LYDIA</u> <u>LOUISE</u> <u>MOORE</u>					4. DATE OF DEATH Month Day Year <u>September</u> <u>23</u> <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 22, 1886</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <u>80</u> yrs. Months <u>8</u> Days <u>0</u> Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico County, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>John P. Phippin</u>					14. MOTHER'S MAIDEN NAME <u>Sarah Jane Hastings</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. (If yes give war or dates of service) <u>214-10-8242</u>		17. INFORMANT Address <u>Mr. William J. Moore (Husband)</u> <u>212 Davis Street, Salisbury, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular renal disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus - acute hyperglycemia</u>								INTERVAL BETWEEN ONSET AND DEATH		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>N/A</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>Salisbury, Maryland</u>				
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>9-23</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-22</u> , 19 <u>66</u> , and that death occurred at <u>12 AM</u> , from the causes and on the date stated above.										
22a. SIGNATURE <u>Philip A. Insley</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Sept 23</u> /1966			
22c. PHYSICIAN'S NAME (Type) <u>Dr. Philip A. Insley</u>					22d. ADDRESS <u>W. Main Street, Salisbury, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 25, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>				
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>					25a. REC'D BY REGISTRAR <u>SEP 27 1966</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

13310

CERTIFICATE OF DEATH

13426

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 22-1		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
3. NAME OF DECEASED (Type or print) First Joseph Middle ALLEN Last MYERS		4. DATE OF DEATH Month September Day 30 Year 1966	
5. SEX Male	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1898
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 7 Days 13 Hours Min. 	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME (unk.)		14. MOTHER'S MAIDEN NAME Mamie Green	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes War I		16. SOCIAL SECURITY NO. 214-10-9667	
17. INFORMANT Mrs. Alma V. Myers (Wife)		Address 103 Prince Street, Salisbury, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COR PULMONARIE 5271 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Obstructive Emphysema & Fibrosis DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June , 19 60 , to Sept 30, 1966 , that (I) (we) last saw the deceased alive on Sept 29, 1966 , and that death occurred at 729 AM , from causes and on the date stated above.			
22a. SIGNATURE Robert T. Adkins		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 30 Sept 66
22c. PHYSICIAN'S NAME (Type) Dr. Robert T. Adkins		22d. ADDRESS Fruitland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 2, 1966	23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR OCT 3 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural)		c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allen Road		d. STREET ADDRESS Main Street	
3. NAME OF DECEASED (Type or print) First VIRGINIA Middle MAE Last OWENS		4. DATE OF DEATH SEPT. 4th 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 8, 1936
9. AGE (In years lost birthday) 29 yrs.		IF UNDER 1 YEAR Months 11 Days 26 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Accounting	
11. BIRTHPLACE (State or foreign country) Wicomico Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Welton L. Johnson		14. MOTHER'S MAIDEN NAME Laura Ann Dennis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-34-5507	
17. INFORMANT Mr. Welton L. Johnson		Address Main St. (Box 411) Hebron, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured neck 825.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple compound fractures of legs			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in car	
20c. TIME OF INJURY Month, Day, Year App 4:00 p.m. 9/4 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway
20f. (City or town) Wicomico Co. Maryland		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. Philip A. Insley		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Main St Salisbury, Maryland		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 7, 1966	
23c. NAME OF CEMETERY OR CREMATORY Spring Hill Memory Gardens, Salisbury, Maryland		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR SEP 8 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge		22. DATE SIGNED Sept. 4 / 1966	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN lb 22-1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Md. d. STREET ADDRESS 704 Olivia Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Alexander Parsons First Middle Last 4. DATE OF DEATH September 20 1966 Month Day Year		5. SEX male 6. COLOR OR RACE negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 3-27-1903 9. AGE (in years last birthday) 63 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 10b. KIND OF BUSINESS OR INDUSTRY Wicomico-Md. 11. BIRTHPLACE (County & State, or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Louis Parsons 14. MOTHER'S MAIDEN NAME Charlotte Dashiell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO 16. SOCIAL SECURITY NO. 704 Olivia St, Salis 17. INFORMANT Catherine Parson Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 150X 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arrival of employee & relatives & lungs DUE TO (c) 18 mos INTERVAL BETWEEN ONSET AND DEATH 18 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 9-1 , 1966, to 9-15 , 1966, that (I) (we) lost saw the deceased alive on 9-15 , 1966, and that death occurred at 12:35 P.M. from causes on and on the date stated above.		22a. SIGNATURE Herbert W. Tiedt M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 9-26-66 22c. PHYSICIAN'S NAME (Type) Herbert W. Tiedt 22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 9-24-66 23c. NAME OF CEMETERY OR CREMATORY Green Acres Mem. Pk. 23d. LOCATION (City or Town) (County) (State) Salisbury, Wicomico Md.		24. FUNERAL DIRECTOR Charlotte B. Jolley - Jersey Rd. Rt 12 Salis. 25a. REC'D BY REGISTRAR SEP 30 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

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MINUTE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital		d. STREET ADDRESS 107 Cherry Street	
3. NAME OF DECEASED (Type or print) Fannie Ellen Pollitt First Middle Last		4. DATE OF DEATH Month September Day 14 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 25, 1883
9. AGE (In years last birthday) yrs. 83		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Shirt Mfg.	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Harry Pollitt		107 Cherry Street Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic 5501 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Paracetamol abuse DUE TO (c) perforated appendix		INTERVAL BETWEEN ONSET AND DEATH - 12 HR - 10 DAY 15 DAY	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary arteriosclerosis -		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/5 - 19 66 to 9/14, 1966 , that (I) (we) last saw the deceased alive on 9 - 14 19 66 , and that death occurred at 5:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE Nevins W. Todd, Jr. M.D.		22b. DATE SIGNED SEP 19 1966	
22c. PHYSICIAN'S NAME (Type) Nevins W. Todd, Jr., M.D.		22d. ADDRESS Medical Center, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 17, 1966	
23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town, or county) (State) Salisbury Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Thomas F. Wallace ADDRESS Salisbury, Md.		25a. REC'D BY REGISTRAR DATE SEP 19 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

11453

CERTIFICATE OF DEATH

CHIEF CLERK

WIDEHILL

20X20410

1
(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13430
CERTIFICATE OF DEATH
13424

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OCEAN CITY d. STREET ADDRESS 3322 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MINNIE KATHRYN POWELL First Middle Last 4. DATE OF DEATH SEPTEMBER 14 1966 Month Day Year		5. SEX FEMALE 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH AUG. 27, 1889 9. AGE (In years last birthday) 77 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INVALID 10b. KIND OF BUSINESS OR INDUSTRY NONE 11. BIRTHPLACE (County & State, or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JAMES O. SAVAGE 14. MOTHER'S MAIDEN NAME JOSEPHINE BUNTING	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO 16. SOCIAL SECURITY NO. 7220 17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatoid arthritis 7220 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 8-20, 1966 to 9-14, 1966 , that (I) (we) last saw the deceased alive on 9-14, 1966 , and that death occurred at 8 A M, from the causes and on the date stated above. 22a. SIGNATURE W. S. Jones 22b. DATE SIGNED 9-14-66 22c. PHYSICIAN'S NAME (Type) W. S. Jones 22d. ADDRESS M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 9-17-66 23c. NAME OF CEMETERY OR CREMATORY MARKINERS BETHEL 23d. LOCATION (City, town or county) (State) OCEANVIEW, DEZ.	
24. FUNERAL DIRECTOR A. Douglas Nelson, Frankford, Del. 25a. REC'D BY REGISTRAR SEP 26 1966 25b. REGISTRAR'S SIGNATURE J. Charles Judge			

1943

Alcohol

Salmon

Peninsula General Hospital

Frank White

1943-19

James J. Jones

1943

1943

James J. Jones

James J. Jones

James J. Jones

James J. Jones

James J. Jones

James J. Jones

James J. Jones

James J. Jones

James J. Jones

James J. Jones

James J. Jones

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13425
CERTIFICATE OF DEATH

13425

1. PLACE OF DEATH a. COUNTY <u>WIDOMCO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WIDOMCO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POWELLVILLE</u>		c. LENGTH OF STAY IN 1b <u>81 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POWELLVILLE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS <u>RFD</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN EDWARD RAYNE</u>				4. DATE OF DEATH Month Day Year <u>SEPT 30 1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 10 1884</u>		9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMP.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>POWELLVILLE MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN GILLIS RAYNE</u>				14. MOTHER'S MAIDEN NAME <u>MAGGIE BETHARDS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>MRS. J. EDWARD RAYNE, POWELLVILLE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Rheumatoid arthritis</u> DUE TO (c) <u>Hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5-7 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Disabled, completely confined to bed for 5 years</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>9-20</u> 19 <u>66</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>day of death</u> , that (I) (we) last saw the deceased alive on <u>9-20</u> 19 <u>66</u> and that death occurred at <u>11:30 AM</u> from the causes and on the date stated above.							
22e. SIGNATURE <u>Frank R. Lewis</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9-24-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Frank R. Lewis</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL <u>BURIAL</u>		23b. DATE THEREOF <u>9-24-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHNS</u>		23d. LOCATION (City, town or county) (State) <u>POWELLVILLE WIDOMCO MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Anna D. Burbage Berlin Md.</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 29 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

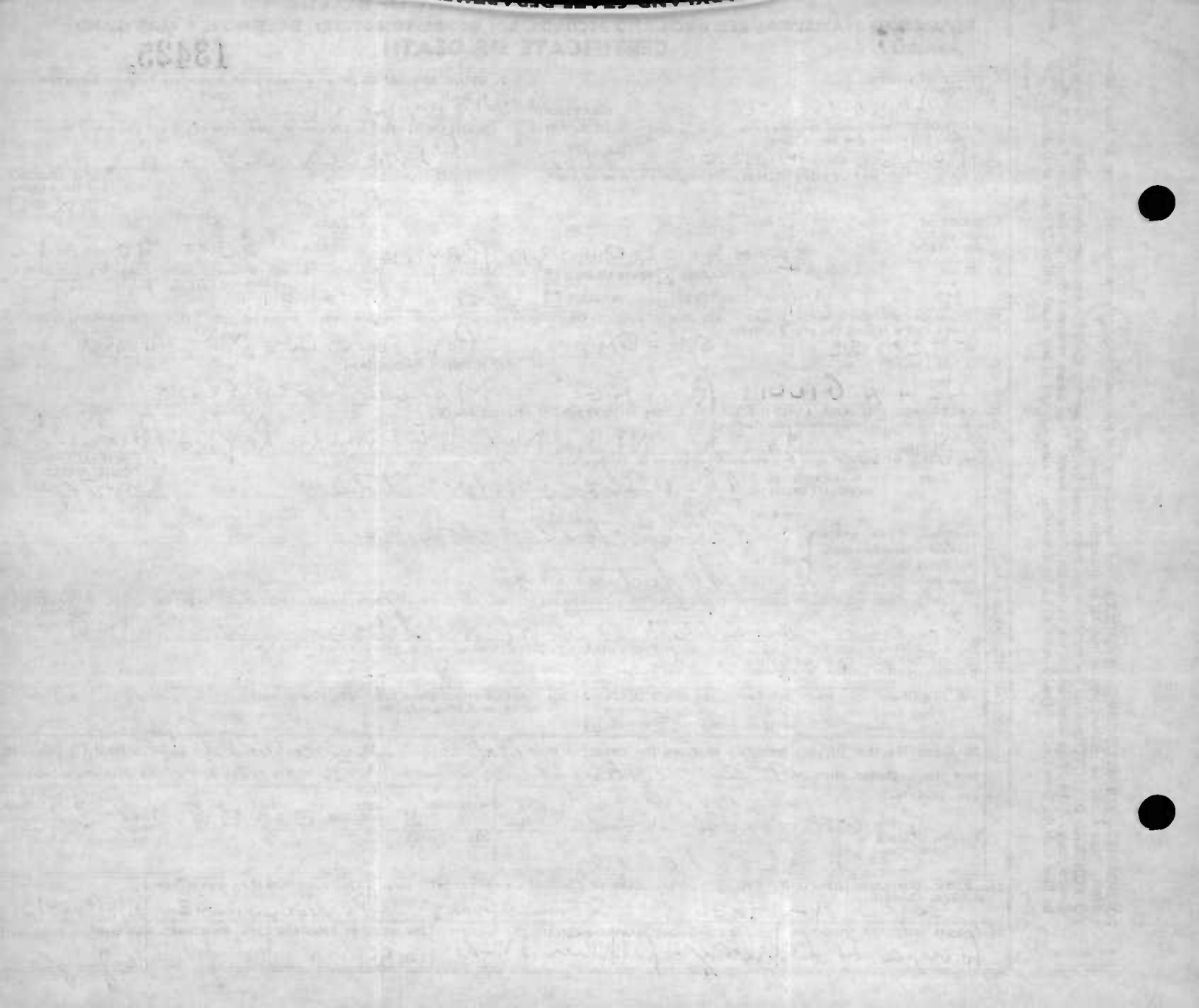
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18433

STATE OF TEXAS

18433



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
13426									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					c. LENGTH OF STAY IN 1b <u>4 Days</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>White Haven</u>				
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					d. STREET ADDRESS <u>22-1</u>				
3. NAME OF DECEASED (Type or print) First <u>CLARK</u> Middle <u>S.</u> Last <u>RAYNOR</u>			4. DATE OF DEATH Month <u>September</u> Day <u>13</u> Year <u>1966</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/5/1893</u>		9. AGE (in years last birthday) <u>72</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Charles Raynor</u>					14. MOTHER'S MAIDEN NAME <u>Betty Dolbey</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes World War I</u>					16. SOCIAL SECURITY NO. <u>None</u>				
17. INFORMANT <u>Audrey Raynor, Salisbury, MD.</u>					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u>Diabetes Mellitus</u>								INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>Unk</u> <u>Unk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/5</u> , 19 <u>66</u> , to <u>9/13</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9/12</u> , 19 <u>66</u> , and that death occurred at <u>3:25 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>George H. Henning</u>								22b. DATE SIGNED <u>9-13-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>George H. Henning</u>								22d. ADDRESS <u>1302 Ocean City Road - Salisbury, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>9/15/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dolbey's Cem.</u>			23d. LOCATION (City, town or county) (State) <u>White Haven, MD.</u>		
24. FUNERAL DIRECTOR <u>Charles Judge</u>						25a. REC'D BY REGISTRAR DATE <u>SEP 15 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1348

Alameda

California

Peninsula General Hospital

March

W. H. H. H.

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 83-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Peninsula General Hospital		d. STREET ADDRESS 423 E. Ocean Ave.	
3. NAME OF DECEASED (Type or print) First TAMMY Middle KAY Last REED		4. DATE OF DEATH Month 9 Day 24 Year 66	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-11-66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY NONE	9. AGE (In years lost birthday) 4 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.
11. BIRTHPLACE (State or foreign country) NORFOLK, VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GERALD REED		14. MOTHER'S MAIDEN NAME IRMA BURNSECL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MR. JOHN REED TOPEKA, KANSAS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull DUE TO (b) 8254 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in auto involved in accident.	
20c. TIME OF INJURY Month, Day, Year 3:45 a.m. 9-24-66		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 13		20f. (City or town) (County) (State) Pocomoke, Worcester, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Earl L. Royer, M.D. 409 Camden Ave., Salisbury, Md.		22. DATE SIGNED Sept. 26, 1966	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/27/1966	
23c. NAME OF CEMETERY OR CREMATORY FOREST LAWN CEMETERY		23d. LOCATION (City or Town) (County) (State) NORFOLK, VA. MD.	
24. FUNERAL DIRECTOR LEVIN R. WILSON Wilson Funeral Home, Princess Anne, Md.		25a. REC'D BY REGISTRAR DATE OCT 3 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

18453

UNITED STATES DEPARTMENT OF JUSTICE

12

X

LEWIS B. BROWN

LEWIS B. BROWN

LEWIS B. BROWN

[Handwritten signature]

LEWIS B. BROWN
LEWIS B. BROWN
LEWIS B. BROWN

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13434

13428

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle GERARD Last SCHLESINGER		4. DATE OF DEATH Month September Day 5 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1916
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 50 yrs. 5 Months 18 Days 10 Hours Min.
11. BIRTHPLACE (State or foreign country) New York (City)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Martin Schlesinger		14. MOTHER'S MAIDEN NAME Frances Kelsey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes War II		16. SOCIAL SECURITY NO. 220-05-5609	
17. INFORMANT Mrs. M. Janet Schlesinger (Wife) Main Street, Mardela, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bullet wound of Brain 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Smother DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute Depression			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 45 cal automatic pistol - Self inflicted wound	
20c. TIME OF INJURY Month, Day, Year 18. 9/5 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) (County) (State) Wicomico Co., Maryland			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer EXAMINER'S NAME (Type) Dr. Earl L. Royer 409 Camden Avenue, Salisbury, Maryland		22. DATE SIGNED Sept. 6 / 1966 Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 9, 1966	23c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery	23d. LOCATION (City or Town) (County) (State) Arlington Virginia
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR SEP 8 1966 DATE	

1945

1945

Black wound of brain

Ante depression

as well as treatment with self-inflicted

Ante depression

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13429

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SNOW HILL</u> 232	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PEN. GENERAL HOSPITAL</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Horace</u> Middle <u>R.</u> Last <u>Shockley</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>16</u> Year <u>1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 20, 1891</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POLICE FORCE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TOWN PET.</u>	
11. BIRTH PLACE (County & State, or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DANIEL HENRY SHOCKLEY</u>		14. MOTHER'S MAIDEN NAME <u>EMMA SCOTT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-12-1764N</u>	
17. INFORMANT <u>MRS. NORMAN COLEBURN</u> Address <u>DEL</u>		Interval BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD.</u> DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obst. Uropathy Benign Prostatic Hypertrophy</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>66</u> , to <u>Sept</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>16 Sept</u> 19 <u>66</u> , and that death occurred at <u>6:58</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph C. Fitzgerald</u>		22b. DATE SIGNED <u>16 Sept 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph Fitzgerald</u>		22d. ADDRESS <u>Medical Center, Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>9/18/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BUCKINGHAM</u>		23d. LOCATION (City, town or county) (State) <u>BERLIN MD</u>	
24. FUNERAL DIRECTOR <u>Amos A. Burbage</u>		25a. REC'D BY REGISTRAR <u>SEP 20 1966</u>	
ADDRESS <u>Berlin Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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13150

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Mass. Penna. b. COUNTY Natick Centre				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 3 Hrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cochituate State College 75-3				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital					d. STREET ADDRESS 228 Nimitz Avenue 92 Dudley Lane			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Roy Middle Southworth Last Jr.					4. DATE OF DEATH Month September Day 4 Year 1966				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 4, 1966		9. AGE (In years last birthday) yrs. 3 Months 30 Days 30 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Work			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas R. Southworth Sr.,					14. MOTHER'S MAIDEN NAME Nancy Abrams				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Thomas R. Southworth Sr., Same				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity (Birth wt 800gms) 776 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 776 X DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 3 1/2 hrs approx.				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 9/4 , 19 66 , to 9/4 , 19 66 , that (I) (we) last saw the deceased alive on 9/4 , 19 66 , and that death occurred at 7:45 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Alfred C. Kolls					22b. DATE SIGNED 9/5/66				
22c. PHYSICIAN'S NAME (Type) Dr. Alfred C. Kolls					22d. ADDRESS Medical Center, Salisbury, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 4, 1966		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery			23d. LOCATION (City, town or county) (State) Salisbury, Maryland		
24. FUNERAL DIRECTOR Hill Funeral Home					ADDRESS Salisbury, Maryland		25a. REC'D BY REGISTRAR SEP 7 1966		
							25b. REGISTRAR'S SIGNATURE Charles Judge		

6-212690

12130

Pennsylvania General Hospital

Investment (8-41-42)

Alfred C. Keller

Medical Center, Baltimore, Md.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and for any event within 72 hours after death.

VR A15ME
3500 4-64

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 4 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 642 S. Division St.		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 642 S. Division St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Leroy Paul First Middle Last 4. DATE OF DEATH September 6 1966 Month Day Year		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Jan. 2, 1907 9. AGE (in years last birthday) 59 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Painter 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME LeRoy Stagg 14. MOTHER'S MAIDEN NAME Lola Rae Stagg	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW II 16. SOCIAL SECURITY NO. 216-14-2127 17. INFORMANT Mrs. Lola Rae Beauchamp Address RFD #1 Westover, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arterio-sclerotic heart disease (c) 4201 DUE TO (b) year. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED 9-7-66	
ACTUAL SIGNATURE Earl L. Royer EXAMINER'S NAME (Type) Earl L. Royer, MD 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 9/8/1966 23c. NAME OF CEMETERY OR INTERMENT Bates Methodist 23d. LOCATION (City, town or county) (State) Snow Hill, Md.		24. FUNERAL DIRECTOR Dennis Funeral Home ADDRESS Snow Hill, Md. 25a. REC'D BY REGISTRAR SEP 9 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

13431

MEDICAL EXAMINER'S OFFICE, CHICAGO, ILL.

32

Chicago, Ill.

February 1, 1911

Mr. J. H. H. H. H.

Chicago, Ill.

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 28th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,
Yours,
J. H. H. H.

Attest: *[Signature]*
J. H. H. H.

[Signature]

9-11

Very respectfully,
J. H. H. H.

Very respectfully,
J. H. H. H.

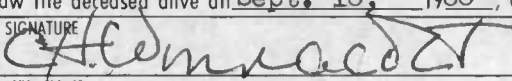
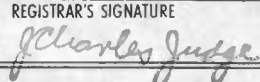
Very respectfully,
J. H. H. H.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13432

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall Rural			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.				d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Romaine Last Strong				4. DATE OF DEATH Month September Day 16 Year 66			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 6/27/1880		9. AGE (In years last birthday) yrs. 86		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer ret. owner		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Thomas R. Strong				14. MOTHER'S MAIDEN NAME Agusta Wickes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 215 36 0634		17. INFORMANT Address Rock Hall, Md. Charlotte Jacquette			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT DUE TO CEREBRAL ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CA OF PROSTATE							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 7, 1966</u> to <u>Sept. 16, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept. 16, 1966</u> , and that death occurred at <u>6:20 M</u> , from causes and on the date stated above.							
22a. SIGNATURE 		22b. DATE SIGNED Sept. 16, 1966		22c. PHYSICIAN'S NAME (Type) C. H. Winnacott, M.D.			
22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/19/66		23c. NAME OF CEMETERY OR CREMATORY ST. PAUL			
23d. LOCATION (City or Town) (County) (State) NARCHESTER TOWN Md							
24. FUNERAL DIRECTOR Wills Wells		25a. REC'D BY REGISTRAR SEP 26 1966		25b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
13433									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>22-1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R.D. #4, Johnson Road</u>					d. STREET ADDRESS <u>R.D. #4, Johnson Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>G.</u> Last <u>STRUSH</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>18</u> Year <u>1966</u>						
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 31, 1883</u>		9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>17</u> Hours <u></u> Min. <u></u>		11. BIRTHPLACE (County & State, or foreign country) <u>Fruitland, Maryland</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Thomas Gray</u>					14. MOTHER'S MAIDEN NAME <u>Margaret (Maggie) Mitchell</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT Address <u>Mrs. Frances Hoppes (Daughter)</u> <u>R.D. #5, Zion Road, Salisbury, Maryland</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>331X</u> DUE TO <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Unk.</u> (c) <u>Unk.</u>									INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>N/A</u>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>March 1, 1966</u> , to <u>9/18, 1966</u> , that (I) (we) last saw the deceased alive on <u>9/14, 1966</u> , and that death occurred at <u>12:41 M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>George H. Henning</u>					22b. DATE SIGNED <u>Sept. 26, 1966</u>				
22c. PHYSICIAN'S NAME (Type) <u>Dr. George H. Henning</u>					22d. ADDRESS <u>Ocean City Road, Salisbury, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 20, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>			
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>					25a. REC'D BY REGISTRAR DATE <u>SEP 27 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
13440 CERTIFICATE OF DEATH 13434										
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury (Rural)					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital					d. STREET ADDRESS St. Luke Road, Box 462			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) (Baby) First Middle Last (Baby) -- Tindall					4. DATE OF DEATH Exp. Month Day Year Sept 15 P.M. 10 1966					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 7:02 P.M. September 10, 1966		9. AGE (In years last birthday) 0 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Salisbury, Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Victor C. Tindall					14. MOTHER'S MAIDEN NAME Frances Elizabeth Purcell					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mr. Victor C. Tindall (Father) Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumaturgy 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 15 min		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9/10, 1966 to 9/10, 1966 , that (I) (we) last saw the deceased alive on 9/10, 1966 and that death occurred at 8:17 P.M. from the causes and on the date stated above.										
22a. SIGNATURE Dr. William B. Smith					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 9/10/66		
22c. PHYSICIAN'S NAME (Type) Dr. William B. Smith					22d. ADDRESS Salisbury, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 12, 1966		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery			23d. LOCATION (City, town or county) (State) Salisbury, Maryland			
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND					25a. REC'D BY REGISTRAR SEP 13 1966					25b. REGISTRAR'S SIGNATURE Charles Judge

6-220012

13481

STATE DEPARTMENT OF HEALTH

13481

Alameda

Salisbury

Tennant's General Hospital

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CERTIFICATE OF DEATH

13435

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN lb 23-2 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE md. b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke d. STREET ADDRESS Box 143 Rt. 3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Girl TOWNSEND		4. DATE OF DEATH Month September Day 22 Year 1966	
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1966
9. AGE (In years lost birthday) yrs. 11		10. BIRTHPLACE (County & State or foreign country) Md.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clarence Townsend		14. MOTHER'S MAIDEN NAME Annette Beckett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT Annette Townsend		Address Route 3 Box 143 Pocomoke City, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis DUE TO (b) Prematurity (3hr-8hr) DUE TO (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 7625			INTERVAL BETWEEN ONSET AND DEATH approx 11 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/22 , 19 66 , to 9/26 , 19 66 , that (I) (we) last saw the deceased alive on 9/22 , 19 66 and that death occurred at 8:30 M, from causes and on the date stated above.			
22a. SIGNATURE Alfred C. Kolls M.D.		22b. DATE SIGNED 9/22/66	
22c. PHYSICIAN'S NAME (Type) ALFRED KOLLS		22d. ADDRESS Medical Center Salisbury Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-24-66	23c. NAME OF CEMETERY OR CREMATORY Home Beneficial	23d. LOCATION (City or Town) (County) (State) Stockton-Worcester, md.
24. FUNERAL DIRECTOR Samuel Savage		25a. REC'D BY REGISTRAR New Church, Va.	
25b. REGISTRAR'S SIGNATURE SEP 27 1966			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13435

CERTIFICATE OF DEATH

1924

Place of Birth

Religion

Residence at Death

Date of Death

Age at Death

U.S.A.

Sex

Occupation

Name

Glenn Townsend
Husband of
Bertha Townsend

Signature

James E. (James E.)

1924

Signature

Signature

Signature

Signature

Signature

Signature

Signature

13442

CERTIFICATE OF DEATH

13436

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shad Point Salisbury Rt. 1 (Rural) d. STREET ADDRESS Rt. 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clifford William Townsend First Middle Last 4. DATE OF DEATH September 15 1966 Month Day Year		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Sept. 29, 1902 9. AGE (In years last birthday) 63 yrs. 10. IF UNDER 1 YEAR Months Days Hours Min. 11 16	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 10b. KIND OF BUSINESS OR INDUSTRY Farming 11. BIRTHPLACE (County & State, or foreign country) Wicomico, Maryland 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William J. Townsend 14. MOTHER'S MAIDEN NAME Sarah Jane Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. 216-38-9909 17. INFORMANT Mrs. Marie T. Townsend (Wife) Address Rt. 1, Shad Point, Salisbury, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melanotic Carcinoma DUE TO (b) Superior Vena Cava Obstruction DUE TO (c) Bronchogenic Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 19. INTERVAL BETWEEN ONSET AND DEATH 6 mos. 3 mos. 18 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Obstructive Airway Disease 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/a			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/a 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3/22 , 19 66 to 9/15 , 19 66 ; that (I) (we) last saw the deceased alive on 9/14/66 , 19 66 , and that death occurred at 6:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Rufus S. Gardner, Jr. 22c. PHYSICIAN'S NAME (Type) Dr. Rufus S. Gardner, Jr.		22b. DATE SIGNED 9/16/66 22d. ADDRESS Medical Center, Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Sept. 18, 1966 23c. NAME OF CEMETERY OR CREMATORY Shad Point Cemetery 23d. LOCATION (City or Town) (County) (State) Shad Point, Wic., Maryland		24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND 25a. REC'D BY REGISTRAR SEP 19 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

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101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000-1001-1002-1003-1004-1005-1006-1007-1008-1009-1010-1011-1012-1013-1014-1015-1016-1017-1018-1019-1020-1021-1022-1023-1024-1025-1026-1027-1028-1029-1030-1031-1032-1033-1034-1035-1036-1037-1038-1039-1040-1041-1042-1043-1044-1045-1046-1047-1048-1049-1050-1051-1052-1053-1054-1055-1056-1057-1058-1059-1060-1061-1062-1063-1064-1065-1066-1067-1068-1069-1070-1071-1072-1073-1074-1075-1076-1077-1078-1079-1080-1081-1082-1083-1084-1085-1086-1087-1088-1089-1090-1091-1092-1093-1094-1095-1096-1097-1098-109

CERTIFICATE OF DEATH

13437

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1 Wk.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wicomico Nursing Home		e. STREET ADDRESS Ellegood St.,	
3. NAME OF DECEASED (Type or print) First Middle Last CARRIE WILLIAMS TRAVERS		4. DATE OF DEATH Month Day Year 9 16 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/21/1878
9. AGE (In years last birthday) yrs. 88		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Williams		14. MOTHER'S MAIDEN NAME Suzannah Moore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs. Willa T. Culver, Same		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept , 19 63 , to Sept , 19 66 , that (H) (we) last saw the deceased alive on Sept 16 , 19 66 , and that death occurred at 2:15 P.M. , from causes and on the date stated above.			
22a. SIGNATURE Robert J. Perkins		22b. DATE SIGNED 9-19-1966	
22c. PHYSICIAN'S NAME (Type) Fruitland, Maryland		22d. ADDRESS Fruitland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-18-1966	23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR ADDRESS Hill Funeral Home Salisbury, Maryland		25a. REC'D BY REGISTRAR DATE SEP 20 1966	25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13444 CERTIFICATE OF DEATH 13438

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS Ocean City Road, Rt. #4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM HEARNE TULL		4. DATE OF DEATH Month Day Year SEPTEMBER 3 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 6, 1907
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Auto Body & Fender	9. AGE (In years last birthday) 59 yrs. 11. BIRTHPLACE (County & State, or foreign country) Laurel, Delaware
13. FATHER'S NAME Adolphus J. Tull		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		14. MOTHER'S MAIDEN NAME Nellie Hearne	
16. SOCIAL SECURITY NO. 214-10-7532		17. INFORMANT Mrs. Mary C. Tull (Wife) Address Rt. 4, Ocean City Road, Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma metastases to liver 1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Primary pulmonary Ca DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH unk. unk.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/25 , 19 66 , to 9/3 , 19 66 , that (I) had saw the deceased alive on 9/3 , 19 66 , and that death occurred at 2:25 P M, from the causes and on the date stated above.			
22a. SIGNATURE George H. Henning		22b. DATE SIGNED Sept. 3, 1966	
22c. PHYSICIAN'S NAME (Type) Dr. George H. Henning		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 6, 1966	23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	23d. LOCATION (City, town or county) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR SEP 8 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

14134

CERTIFICATE OF DEATH

14134

Wicomico

Delaware

Peninsula General Hospital

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1-1-68

RECEIVED
FEB 11 1968
U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
DIVISION OF VITAL STATISTICS

13445

CERTIFICATE OF DEATH

13439

1. PLACE OF DEATH a. COUNTY WICOMICO b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Royal Oak e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Helen Elizabeth Wallace			4. DATE OF DEATH Month September Day 16 Year 19 66				
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-25-1901	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY FACTORY		11. BIRTHPLACE (County & State, or foreign country) Talbot, Md			
13. FATHER'S NAME JAMES MACKAY			14. MOTHER'S MAIDEN NAME MARY SKINNER				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-18-2343A		17. INFORMANT Hospital Records Address Salisbury, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO (b) Generalized arteriosclerosis DUE TO (c) Diabetes mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus					INTERVAL BETWEEN ONSET AND DEATH 48 hrs. years		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from Sept. 12 , 19 66 , to Sept 16 , 19 66 that (I) (we) last saw the deceased alive on Sept. 16 , 19 66 , and that death occurred at 9:40a M, from causes and on the date stated above.							
22a. SIGNATURE W. Walden			22b. DATE SIGNED 9/16/66				
22c. PHYSICIAN'S NAME (Type) Dr. L. V. Maldve			22d. ADDRESS Deer's Head State Hospital, Salisbury Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-20-66		23c. NAME OF CEMETERY OR CREMATORY Royal Oak Cem			
23d. LOCATION (City or Town) Royal Oak Tal. Md							
24. FUNERAL DIRECTOR James D. Whell, Boston, Md.			25a. REC'D BY REGISTRAR SEP 21 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal of the body. If any event, within 72 hours after death.

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STATE OF NEW YORK

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 (M)

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13446

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13440

1. PLACE OF DEATH a. COUNTY Salisbury, Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b D.O.A. life?		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital			d. STREET ADDRESS 316 Poplar Hill Ave.		
3. NAME OF DECEASED (Type or print) Robert Henry			4. DATE OF DEATH Sept. 18, 1966		
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH July 7, 1900			9. AGE (In years last birthday) 66 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) painter			10b. KIND OF BUSINESS OR INDUSTRY self employed		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Henry Waller			14. MOTHER'S MAIDEN NAME Emma Ellegood		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 220-16-9586		
17. INFORMANT Mr Carroll E. Bounds, Salisbury, Md.			Address		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4344 Congestion and Edema of Lungs DUE TO (b) Hypertrophy and Dilatation of Heart. DUE TO (c) minutes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH years
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE Kendrick Mc. Cullough M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED Sept. 18, 1966		
EXAMINER'S NAME (Type) Kendrick Mc. Cullough M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
		Address (Street, city, town, or county)				

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-21-1966	23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR Hill Funeral Home ADDRESS Salisbury, Maryland		25a. REC'D BY REGISTRAR SEP 26 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~remove~~ ^{attach} carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
13447 Item #2 & 3 Infor. taken from birth cert. 13442																			
CERTIFICATE OF DEATH																			
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wic.</u>														
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>														
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>					d. STREET ADDRESS <u>707 North Westover Dr.</u>														
3. NAME OF DECEASED (Type or print) First <u>Twin I</u> Middle <u>WHALEY</u> Last <u>WHALEY</u>					4. DATE OF DEATH <u>SEPTEMBER 13</u> 19 <u>66</u>														
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 12, 1906</u>		9. AGE (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR Months <u>1</u> Days <u>10</u> Hours <u>16</u> IF UNDER 24 HRS.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>ANDREW WHALEY</u>					14. MOTHER'S MAIDEN NAME <u>JOANNE BRIDGELL</u>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>1-220</u>					17. INFORMANT <u>Joanne Bridgell Salisbury</u> Address <u>Salisbury, Md</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity (625 gm.)</u> 776X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>776X</u> DUE TO (c) <u>776X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>776X</u>										INTERVAL BETWEEN ONSET AND DEATH <u>34 hr. 16 min.</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)					20g. (City or town) (County) (State)					20h. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>9/12, 1966</u> , to <u>9/13, 1966</u> , that (I) (we) last saw the deceased alive on <u>9/13, 1966</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.										22a. SIGNATURE <u>D. S. Anderson</u>									
22b. DATE SIGNED <u>9/13/66</u>					22c. PHYSICIAN'S NAME (Type) <u>DANIEL ANDERSON</u>					22d. ADDRESS <u>1000 N. West</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>Sept 18, 66</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Crown Acres</u>									
23d. LOCATION (City, town or county) (State) <u>Salisbury Md</u>					24. FUNERAL DIRECTOR <u>Doakes McWest</u>					25a. REC'D BY REGISTRAR <u>SEP 20 1966</u>									
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>																			

13447

13447

Wisconsin

Salisbury

General Hospital

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "General Hospital" and "Salisbury" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
23448					13443									
Items #2 & 3 info, taken from birth cert.														
1. PLACE OF DEATH a. COUNTY Wicomico					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE md b. COUNTY Wic.									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital					d. STREET ADDRESS 707 North Westover Dr.									
3. NAME OF DECEASED (Type or print) First Twin Middle II Last WHALEY					4. DATE OF DEATH Month September Day 12 Year 1966									
5. SEX male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 12, 1940		9. AGE (In years last birthday) yrs. 25 Months 5 Days 12 Hours 5 Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Wicomico Co.		12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME ANDREW WHALEY					14. MOTHER'S MAIDEN NAME JOANNE BRIDDELL									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. 1					17. INFORMANT JOANNE BRIDDELL Address Salisbury MD				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity (Birthwt 660 gms) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 776 X DUE TO (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH approx 5 1/2 hrs										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) _____ (County) _____ (State) _____					20g. (City or town) _____ (County) _____ (State) _____					20h. (City or town) _____ (County) _____ (State) _____				
21. I certify that (I) (this hospital) attended the deceased from 9/12, 1966 to 9/12, 1966 that (I) (we) last saw the deceased alive on 9/12, 1966 and that death occurred at 8:30 A.M. from the causes and on the date stated above.														
22a. SIGNATURE Alfred C Koller					22b. DATE SIGNED 9/12/66									
22c. PHYSICIAN'S NAME (Type) Alfred C Koller					22d. ADDRESS Medical Center Salisbury Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried					23b. DATE THEREOF Sept 18 1966					23c. NAME OF CEMETERY OR CREMATORY Green Acres				
23d. LOCATION (City, town or county) _____ (State) _____					23e. LOCATION (City, town or county) _____ (State) _____					23f. LOCATION (City, town or county) _____ (State) _____				
24. FUNERAL DIRECTOR Booker M West					ADDRESS Salisbury Md					25a. REC'D BY REGISTRAR SEP 20 1966				
25b. REGISTRAR'S SIGNATURE Charles Judge					25c. REGISTRAR'S SIGNATURE Charles Judge					25d. REGISTRAR'S SIGNATURE Charles Judge				

13448

13448

Alconico

Salisbury

Portland General Hospital

Walla

Walla

Walla

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13449					13444				
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R.D.#2 (Walnut Tree Rd.)					d. STREET ADDRESS R.D.#2 (Walnut Tree Rd.)			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle WALTON Last WHITE			4. DATE OF DEATH Month September Day 22 Year 1966						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 20, 1908		9. AGE (In years last birthday) 57 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Wicomico County, Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Noah White				14. MOTHER'S MAIDEN NAME Adele Malone					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --		17. INFORMANT Mrs. Ethel M. White (wife) R.D. #2, Eden, Maryland		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronary atherosclerosis</u> DUE TO (c) <u>None</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>								INTERVAL BETWEEN ONSET AND DEATH MIN YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>5-25, 1965</u> , to <u>9-22, 1966</u> , that (I) (we) last saw the deceased alive on <u>9-2, 1966</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Hubert R. White, Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9-23-66</u>			
22c. PHYSICIAN'S NAME (Type) Dr. Hubert R. White, Jr.				22d. ADDRESS Fruitland, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 25, 1966		23c. NAME OF CEMETERY OR CREMATORY Siloam Cemetery		23d. LOCATION (City, town or county) (State) Wicomico County Siloam, Maryland			
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR DATE SEP 26 1966		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1944

OFFICE OF THE SECRETARY OF THE ARMY

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CERTIFICATE OF DEATH

13450

13445

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Vernon</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>R. F. D. 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Brice</u> Middle <u>M.</u> Last <u>Williams</u>				4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>28</u> Year <u>1966</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 8, 1900</u>		9. AGE (In years lost birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired clerk</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Retailing</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Mt. Vernon, Md.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>William Williams</u>			
14. MOTHER'S MAIDEN NAME <u>Vida Scott</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mrs. Brice Williams, Princess Anne</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral vascular thrombosis</u> DUE TO (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>yes</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 25, 1966</u> , to <u>Sept 28, 1966</u> that (I) (we) last saw the deceased alive on <u>Sept 28, 1966</u> , and that death occurred at <u>12:20</u> PM, from causes and on the date stated above.							
22a. SIGNATURE <u>John Bulkeley</u> M.D.				22b. DATE SIGNED <u>9-28-66</u>		22c. PHYSICIAN'S NAME (Type) <u>John Bulkeley</u>	
22d. ADDRESS <u>Salisbury, Md.</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>9/30/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Mt. Vernon, Somerset, Md.</u>			
24. FUNERAL DIRECTOR <u>Lenon R. Wilson, Princess Anne, Md.</u>				25a. REC'D BY REGISTRAR <u>OCT 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1520

2464

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13446

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN TB 46-3 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DELAWARE b. COUNTY SUSSEX c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DELMAR d. STREET ADDRESS 304 E. ELIZABETH ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LELAND WILSON Williams		4. DATE OF DEATH September 20 1966	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 28, 1904
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FREIGHT CONDUCTOR		10b. KIND OF BUSINESS OR INDUSTRY PENNA RAILROAD	
11. BIRTHPLACE (County & State, or foreign country) DELAWARE		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EDWIN MERRITT WILLIAMS		14. MOTHER'S MAIDEN NAME MARIAH STURGES ALLEN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT NELLIE SPARKS WILLIAMS		Address DELMAR, DEL.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung with 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastases to Liver and Brain DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from August 21, 1966 to Sept 20, 1966 , that (I) (we) last saw the deceased alive on September 19, 1966 , and that death occurred at 7:04 A.M. from causes and on the date stated above.			
22a. SIGNATURE Thomas C. Hill Jr.		22b. DATE SIGNED 9/20/66	
22c. PHYSICIAN'S NAME (Type) THOMAS C. HILL JR.		22d. ADDRESS PINE BLUFF RD., SALISBURY, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF SEPT 22 1966	23c. NAME OF CEMETERY OR CREMATORY ODD FELLOWS CEMETERY	23d. LOCATION (City or Town) (County) (State) SEAFORD, DELAWARE
24. FUNERAL DIRECTOR Paynter M. Watson - SEAFORD, DEL.		25a. REC'D BY REGISTRAR SEP 22 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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13448

CERTIFICATE OF DEATH

13448

DECEASED		DATE OF DEATH	
PLACE OF DEATH		CAUSE OF DEATH	
AGE		SEX	
BIRTH DATE		BIRTH PLACE	
MARRIAGE DATE		MARRIAGE PLACE	
OCCUPATION		EDUCATION	
RELIGION		RACE	
SIGNED		WITNESSED	
DATE		PLACE	
BY		AT	
FOR		BY	
IN		AT	
ON		ON	
AT		AT	
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OF		OF	
THE		THE	
STATE		STATE	
OF		OF	
NEW		NEW	
JERSEY		JERSEY	
U.S.A.		U.S.A.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury						c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital (D.O.A.)											
3. NAME OF DECEASED (Type or print) First BERNICE Middle MAE Last WILLING			4. DATE OF DEATH Month September Day 4 Year 1966			5. SEX Female			6. COLOR OR RACE White		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH April 7, 1901			9. AGE (In years last birthday) 65 yrs.			IF UNDER 1 YEAR Months 4 Days 7 Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Mardela, Maryland		
12. CITIZEN OF WHAT COUNTRY? USA						13. FATHER'S NAME Beauchamp Gillis					
14. MOTHER'S MAIDEN NAME Mary Bennett						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -- (If yes give war or dates of service) --					
16. SOCIAL SECURITY NO. 213-14-6222						17. INFORMANT Mr. Raymond Willing (Husband) Rt. #1, (Athol Road) Mardela, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 287X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Tachycardia for B.P. DUE TO (c) And obesity											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from — suddenly — to — , 19 — , that (I) (we) last saw the deceased alive on — 19 — , and that death occurred at — from the causes and on the date stated above.											
22a. SIGNATURE Fred C Quinn M.D.						22b. DATE SIGNED Sept. 9 / 1966					
22c. PHYSICIAN'S NAME (Type) Dr. Fred C. Quinn						22d. ADDRESS Mardela, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE THEREOF Sept. 7, 1966					
23c. NAME OF CEMETERY OR CREMATORY Mardela Cemetery						23d. LOCATION (City, town or county) (State) Mardela, Maryland					
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND						25a. REC'D BY REGISTRAR SEP 9 1966					
25b. REGISTRAR'S SIGNATURE Charles Judge											

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1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13448

1. PLACE OF DEATH a. COUNTY Wicomico County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1071 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.		d. STREET ADDRESS 107 Caroline St.	
3. NAME OF DECEASED (Type or print) First Elma Middle Mae Last Wise		4. DATE OF DEATH Month 9 Day 12 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 16, 1895
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 7 Days 12 Hours 19 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) SMYRNA DEL		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NATHANIEL CAREY		14. MOTHER'S MAIDEN NAME ELMA FRAZIER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 173-05-3731	
17. INFORMANT MR. HOWARD C. WISE		Address OCEAN CITY MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral DUE TO (b) Recurrent cerebral thrombosis DUE TO (c) 332X		INTERVAL BETWEEN ONSET AND DEATH 1 month 4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/7 , 19 63 , to 9/12 , 19 66 , that (I) (we) last saw the deceased alive on 9/12 , 19 66 , and that death occurred at 5:10 PM , from causes and on the date stated above.			
22a. SIGNATURE W. Maldve		22b. DATE SIGNED 9/12/66	
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/15/66	
23c. NAME OF CEMETERY OR CREMATORY ODD FELLOWS		23d. LOCATION (City or Town) (County) (State) SMYRNA DEL	
24. FUNERAL DIRECTOR Anne R. Burbage Belton Md.		25a. REC'D BY REGISTRAR DATE SEP 15 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1948

STATE OF TEXAS

1948

COUNTY OF _____	
CITY OF _____	
STATE OF TEXAS	
I, _____, of the County of _____, State of Texas, do hereby certify that _____ is a resident of the County of _____, State of Texas, and is entitled to the benefits of the _____ Act of the _____ Legislature, Chapter _____, Acts _____, 1948.	
WITNESSED my hand and seal this _____ day of _____, 1948.	
_____ My Commission Expires _____	
_____ Notary Public for the State of Texas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 12 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield d. STREET ADDRESS Jacksonville Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle M. Last Woolston Jr.		4. DATE OF DEATH Month September Day 9 Year 1966	
5. SEX male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 14, 1916	
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months 50 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Producer & Dealer		10b. KIND OF BUSINESS OR INDUSTRY Seafood	
11. BIRTHPLACE (County & State, or foreign country) Crisfield, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles M. Woolston, Sr.		14. MOTHER'S MAIDEN NAME Willie Mae Landon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Elizabeth Woolston, Same as 2. abcd		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphocytic Lymphoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2021 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Ischiorectal Abscess		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 29, 1966 to Sept 9, 1966 , that (I) (we) last saw the deceased alive on Sept 9, 1966 , and that death occurred at 7:50 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Thomas C. Hill Jr.		22b. DATE SIGNED Sept 10, 1966	
22c. PHYSICIAN'S NAME (Type) Thomas C. Hill, Jr.		22d. ADDRESS PINE BLUFF Rd., Salisbury, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 12, 1966	
23c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery		23d. LOCATION (City, town or county) (State) Crisfield, Maryland	
24. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Maryland		25a. REC'D BY REGISTRAR SEP 14 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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James G. Hill

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
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CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE DELAWARE b. COUNTY SUSSEX c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) DELMAR d. STREET ADDRESS RT #3 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EVA B. YEADT 4. DATE OF DEATH Month Day Year SEPTEMBER 5 1966		5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 3-2-1901 9. AGE (In years last birthday) 65 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) N.Y. 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME THOMAS BISHOP 14. MOTHER'S MAIDEN NAME EVA GILLIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 16. SOCIAL SECURITY NO. 221-308192 17. INFORMANT Robert Yeardt-DeLamar Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 584X Acute Pancreatitis (b) Chronic Cholecystitis (c) Cholelithiasis CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 8:20, 1966 to 9:15, 1966, that (I) (we) last saw the deceased alive on 9-5-66 1966, and that death occurred at 9:15 M, from the causes and on the date stated above. 22a. SIGNATURE H. H. Brielle 22b. DATE SIGNED 9-5-66 22c. PHYSICIAN'S NAME (Type) H. H. Brielle 22d. ADDRESS Medical Center	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 9-8-66 23c. NAME OF CEMETERY OR CREMATORY St. Stephens Cemetery 23d. LOCATION (City, town or county) (State) Salisbury, Md.		24. FUNERAL DIRECTOR Charles W. Harrel 25a. REC'D BY REGISTRAR DATE SEP 8 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

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WEST OF DEATH

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